

**Linear versus Ecological Perspective
in Clinical Judgments of Social Work Students**

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ABSTRACT

Linear versus Ecological Perspective in Clinical Judgments of Social Work Students

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This study explores the dialectic between the older, linear-mechanistic approach of the clinical-normative-individual-system model, and the newer, ecological-systems approach of the life model. Theoretical issues are outlined as they have unfolded during several decades.

The principal independent variable is clinical-orientation of clinician-subjects with regard to degree of adherence to linear-mechanistic and/or ecological-systems approaches. Secondary independent variables are duration-severity and interpersonal-context of client problem/situations, described in four situational vignettes. Hypotheses predict positive correlations between measures of each independent variable, and degree of linear *versus* ecological weighting to clinicians' assessments and intervention plans for each vignette.

Data were collected in 1980 from 152 second-year graduate students in casework and direct practice, who represented an initial pool of 1,007 students from fourteen CSWE-approved schools which provided unrestricted cooperation, through lists of eligible students.

Three instruments were utilized: (a) An informational questionnaire inquired about students' willingness to participate, and characteristics which would enable the researcher to determine eligibility, and identify extraneous effects. (b) The second sought graded measures of subjects' adherence to specific theoretical principles of linear or ecological approaches. (c) The final instrument sought repeated measures of type of assessment and intervention plan (linear or ecological), formulated in response to systematically varied vignette conditions.

Findings include several positive correlations between self-rated clinical-orientation and assessment measures, and fewer positive correlations between clinical-orientation and intervention measures. The interpersonally isolated client whose problem/situation is chronic tends to pull judgments in the direction of linear-mechanistically weighted assessments and intervention plans, regardless of clinician's orientation.

Implications for teaching the ecological approach are explored. Use of the clinical-orientation instrument for student self-observation is suggested.

Research implications include refining of instrumentation, and comparison of seasoned and student clinicians, to test empirical applicability of the ecological approach.

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CHAPTER I

Introduction

Prior to the presentation of this research study, major concepts of the current dialectic between the new and the old in contemporary social work practice, will be traced and brought together through a historical-theoretical literature review. The review is divided into material which appeared (a) *before* the period 1978, 1979 and 1980, which are the respective years in which the design for our research was fully proposed, finalized, and carried out; and (b) from 1978 to the present. The intent of the review is not to be comprehensive, but to be focused on both (a) the salient historical and theoretical backdrop in which the dialectic developed; and (b) the relevant conceptual elements of both the old and the new alternatives which serve as the bases for our instrument development.

Two major contextual considerations of the research are noted. First, it was done at a moment in which the full technology of the life model was about to emerge but had not yet made its impact. Second, subjects were second year graduate social work student interns, whose practice experience and understanding were clearly in the process of development.

The literature in the two decades prior to the late 1970's had seen efforts to apply systems theory to social work practice. Applied systems theory, drawn from the physical sciences and adapted to the biological sciences, deals with man as a social and

biological organism of systematically and purposefully organized complexity. An ecological approach, conceived in the interaction of biological organisms with one another and with their physical environment, refers to all aspects of man's environment, including his physical environment within a systemic framework. The life model attempts to structure practice over time within the framework of this organized complexity, rather than removed from it. A systems theory framework provides a set of principles for understanding man. The life model presents an approach to practice within that framework. Central is the emphasis on health and growth over disease and pathogenesis.

A linear-mechanistic framework explains man from a chronological, cause-effect viewpoint. The tendency is to isolate one partial cause-effect chain at a time, to analyze it apart from its broader internal and social contexts. The focus is on the individual, who is to some degree disabled by a problem. The source of the problem must be understood, so that it may be corrected or "cured" within that person. Origins of this vantage point may be traced to casework's early incorporation of a nineteenth century "scientific" attitude that all matter and phenomena, both living and non-living, could be understood by reduction to basic laws of physical science.

The applicability of the "clinical-normative-individual-system" model to *social variables* would seem to be limited by its origin in principles of intrapsychic and psychosocial determinism and linear causality. For practitioners and researchers who wish

to account for phenomena of organized complexity (in which linear, historically traceable, individually-oriented problems are not central) this approach appears to be less useful (Lutz, 1968).

The "unit of attention" describes the cognitive field within which a practitioner defines and conceptualizes the people, their environment and the problems presented. It provides the viewpoints for understanding and the options for intervention. We will trace the historical-theoretical development of the unit of attention, first in the linear-mechanistic world-view, as it expanded its capacity to "scientifically" incorporate the complexities of being human in the twentieth century. We will then look at the development of the ecological-systems approach in social work practice as an alternative world-view to helping people in need.

The originating idea, at the time this study was conceived, was to contrast the understanding and application of the newer systems approach of the then-developing life model against the linear-mechanistic approach of the "clinical-normative-individual-system" model. This research represents an early, limited effort to test and compare, in operational terms, some conceptual elements of the old and the new approaches to practice.

Systems theory and the ecological approach may be seen as complementary and combinable into an ecological-systems approach. This approach, in turn, may be seen as providing the social-scientific perspective for the life model.

This research has attempted to advance knowledge in social work in three ways. First, it has explored whether or not among a large group of second year social work student intern clinicians, there are stated differences in clinical orientation (linear-mechanistic *versus* ecological-systems). Second, the study has explored whether or not in simulated practice situations, there are differences in proposed assessment and intervention plans between interns who tend to adhere to principles of a linear-mechanistic approach and those who tend to adhere to principles of an ecological-systems approach. Third, the study has sought to understand what might contribute to such differences.

The originating idea was to test the newer ecological systems approach to practice as an "alternate recommendation"¹ to the older linear-mechanistic approach. More pointedly, we have sought to determine if there are discernable differences in the following *specifying questions*: (a) What do social work student interns actually say they believe about their practice in relation to linear-mechanistic and ecological-systems principles? (b) What is the relationship between *what social work student clinicians say they believe about their practice perspectives*, and the *kinds of assessments and intervention plans they say they would develop and and utilize* in specific simulated practice situations?

This study tests for differences which emerge from the second specifying question through the development and use of two main instruments. The first instrument attempts to measure differences in what social work student clinicians say they believe about their

practice orientations. The second attempts to measure differences in assessments and intervention plans in specific simulated practice situations for social work student clinicians who indicate that they adhere to principles of the two practice perspectives under study.

To address the second specifying question, an attempt was made to test for differences in what social work student clinicians do in markedly different simulated practice situations. Two main *variables* which affect such differences were chosen, based on what, theoretically and pragmatically, would be expected both to affect clinical judgment, and to draw upon the preferences and biases which would be linked to the two clinical orientations in question. One variable, *interpersonal-context* of problem/situation, refers to whether a client's problem/situation is reflective of either an interpersonally *involved* life context or a socially/ interpersonally *isolated* life context. The second variable, *duration-severity* of problem/situation, refers to whether a client's problem/situation is of an *acute*, more recent or reactive nature, as opposed to a *chronic*, more longstanding, lifelong nature. In linear-mechanistic terms, these differences refer to opposite extremes of psychopathology.

The two variables, interpersonal-context and duration-severity, together point to a narrower issue from the second specifying question: Are there differences in what social work student clinicians do in specific simulated practice situations in the development of case assessments and intervention plans when

the problem/situation varies according to interpersonal-context and/or duration-severity?

Two broad sets of concepts were drawn from the literature. These provided basic theoretical background for development of the two main instruments which were utilized in this study.

The first set was a comparative grouping of principles which may be said to distinguish theoretically between the two alternative orientations to the understanding of problem/situations of people. These principles appear in Figure 1, Chapter IV. They serve as the basis of the study's first instrument which distinguishes self-perceived theoretical-orientations of clinicians. Examples include a clinician's predilection to think about the work in terms of linear causality as opposed to equifinality; or to focus on regressive as opposed to progressive forces in efforts to understand people.

The second set of concepts is represented by a number of specific, comparative sets of operationalized criteria which were developed to distinguish whether a clinician's actual assessments and intervention plans reflect linear-mechanistic or ecological-systems type responses (or mixtures of both). These criteria are presented later in Chapter IV, in Figures 2 and 3. They are incorporated into the construction of the instrument which operationally tests our hypotheses. There are five such criteria for assessment and nine of these for intervention plans. Examples include distinctions between a clinician's focus on personality deficits as opposed to personality strengths in assessment and in

intervention planning; on history as opposed to current factors for assessment; or on use of office versus life context for location of interventions.

The emphasis in the first set is on general theoretical principles. The emphasis in the second set is on operationalized aspects of practice-related, specific orientation in thought and action in clinical work. The first stresses a basic orientation to the world of people in problem/situations, based on alternative theoretical explanations of what makes things happen. The second stresses specific issues in understanding and intervening in case situations. It is based on alternative views of what to look for and what to do in actual practice.

While the first and the second sets of concepts for each school of thought are related, in that they measure and compare similar ideas, they do *not* measure and compare the same things. The first deals with comparisons of inherent world views. The second compares specific guidelines for understanding and action.

The notion of *alternate* rather than *opposed* is vital. It emphasizes this researcher's efforts to compare two clusters of principles which represent alternative world views. The newer view may be said to have grown out of some clinicians' efforts to utilize the older view in a changing world. Therefore, they are different but related. Furthermore, the notion of *alternate* emphasizes that social work is still developing as the world is changing, and that there are no static absolutes. It also stresses

that the newer view has, by no means, replaced the older one among many clinicians (see footnote 1).

Following this introduction, a historical-conceptual literature review will be presented to prepare the reader for the research study. The shift in epistemology in science and social science prior to and during the twentieth century will be described as a backdrop for understanding the shifts in world view in the development of social work practice. The development of an expanding, increasingly holistic and organismic view of social work practice from its nineteenth century inception in a linear-mechanistic framework through the beginnings of the ecological-systems approach of the life model will be summarized. In this progression, this author will (a) outline relevant benchmarks in the historical development of casework theory as well as contributions (b) from psychoanalysis, (c) from group work, and (d) from family practice conceptions. (e) The initial development of the life model through the late 1970's, which is when this research was proposed will be followed by (f) developments from approximately 1978 to the present to show main themes and new concepts in elaborations of life model which did not exist when this research was undertaken. The sections in Chapter II recount an overview of relevant conceptual developments of the old and the new over extended periods of time. The sections in Chapter III, on more recent developments in the life model, draw on a limited but seminal selection from the literature as a means of presenting a range of essential concepts.

CHAPTER II

Theoretical and Historical Considerations

About Approaches to Practice until the Late 1970's

Epistemology: Some Notes on Ways of Knowing

For Lincoln and Guba (1985, p. 15) a systematic set of basic (metaphysical) beliefs about reality which can never be proven, plus their methods for inquiry and understanding, constitutes a *paradigm*. Paradigms reflect an essence of what we *think* (but cannot prove) about the world. Our actions and inquiry occur in relation to those paradigms: "As we think, so do we act."

Kuhn (1970) addresses shifts in shared views about the nature of the world for science with implications for similarities in social science. He sees a paradigm within a scientific community as a "disciplinary matrix" (p. 182), a constellation of shared commitment to basic beliefs about the world and to ways of ordering knowledge toward the solution of problems which need to be addressed (pp. 174-210). A paradigm gains status and promise by showing more success than competitors in solving a few acute problems satisfactorily over time (pp. 23, 23-51).

For Kuhn (1970) new phenomena which contradict expectation, when repeatedly uncovered, produce "awareness of anomaly" (1970, p. 52). He describes a scientific community as first trying to understand anomaly within its contemporary paradigm, or if necessary, adjusting the paradigm. Existing knowledge is utilized

to the fullest to understand the problem before a paradigm change is needed (pp. 52-65). Lingerig, unresolved anomalies present emerging crises, while an incremental, cumulative process of data collection and minor paradigm adjustment lay the groundwork of readiness for a paradigm shift (pp. 66-91). When a paradigm's tools no longer solve the problems which it defines, a crisis ensues, with extravagant *retooling*, an effort "reserved for the occasion that demands it" (p. 76).

When in response to crisis, a scientific community rejects a paradigm, it simultaneously accepts another, in a process through which the two paradigms are compared with nature, and with one another (Kuhn, 1970, p. 77). Crisis blurs a paradigm and loosens usual rules for inquiry, observes Kuhn (p. 84). A scientific revolution is a non-cumulative developmental episode; "an older paradigm...is replaced in whole or in part by an incompatible new one" (p. 92), in a qualitative shift in view about how to practice science (pp. 157-8). While an old and new paradigm may involve the same phenomena, they are incompatible because they organize data in qualitatively different ways. The new may encompass dilemmas to which the old was refractory, and thereby lead to new discovery (pp. 92-135).

Lincoln and Guba (1985) describe ways of knowing and inquiring about truth during three sequential paradigm periods in the Western World: These are the (a) "prepositivist," (b) positivist and (c) postpositivist or naturalist periods. The "prepositivist" period mirrors the view of Aristotelian science from

the fourth century B.C., in which knowledge was deductively advanced by means of passive, non-interfering observation, which would not distort what was learned. More than two millenia after Aristotle when scientists began to be *active* observers who would inductively try out ideas to see what worked, science moved into the positivist period (pp. 18-19).

Lincoln and Guba (1985, pp. 19-24) discuss positivism's reflection in both science and social science where identical methodologies are seen as serving identical aims. These aims are inductive derivation of universal, testable laws of nature, whose basic elements consist of the components of the universe and the mechanics of their predetermined motion. In this Newtonian, mechanistic, reductionist model, observation is seen as disturbing the data collection, but not the basic motion or complex phenomena which are observed. Error of observation can be accounted for by analysis of the observation, itself.

The authors (1985, pp. 24-8) speak of positivism's failure to conceptualize science adequately by seeing it as non-cognitive and non-rational, with emphasis on verification over discovery; on prediction over understanding, description and problem-response; on operational facts over meanings or implications. Operationalism is criticized for the limitations (a) placed on human free will by *determinism* and on (b) alternate views of scientific understanding by *reductionism*. Most seering is their criticism of positivism's axiomatic assumptions that (a) there is a single reality equal to the sum of its parts; (b) an observer can be separated from the

observed; (c) (repeatable) observations are independent of their contexts in time and space; (d) effects have causes in time; and (e) scientific results are rendered value-free by methodology.

Germain (1970, p. 29) speaks of a crisis in casework's commitment to a scientific metaphor which had become outmoded, in light of the changes both in science and in the human condition. Casework had not advanced with science to "deal with problems of growth, change, and potentiality...", in a view which eliminates "the dichotomy of object and space...person and situation."

Schwartz (1976, pp. 174-5) addresses the issue of anomaly in contemporary social work: "We too have our received beliefs, embodied in the paradigm of study-diagnosis-treatment, as it was taken over from medicine, research and positivist science." These beliefs embody a consensual language which frames "certain kinds of questions and...no others." Such anomaly includes contradictions between theoretically sequential and actually simultaneous conceptions of study-diagnosis-treatment; prescriptiveness and self-determination; detachment and empathy; changing people and helping them; and general difficulty in living with the subject-object view of the helping relationship.

In describing the postpositivist, *naturalist* paradigm, Lincoln and Guba (1985, pp. 36-8) restate the five axiomatic assumptions from a naturalist viewpoint: (a) Realities are multiple and can be studied only holistically toward understanding them, with little likelihood of prediction or control. (b) Both observer and

observed have inseparable interactive influence upon one another. (c) Inquiry's aim is to form descriptive understanding of individual situations which may not be repeatable in the context of other times and places. (d) Entities mutually and simultaneously shape one another, so that cause and effect cannot be distinguished. (e) Results of inquiry are influenced by values of the inquirer, of the paradigm, and of the substantive theory which guides the inquiry, as well as by the inquiry's context. Results are meaningful to the extent to which they are congruent with these factors.

The naturalist assumptions, for whose primacy Lincoln and Guba argue, present radical alternatives to their predecessors.

A simplified framework has been utilized for understanding changes in epistemology in science and social science, and the shift from a positivist to a naturalist paradigm during the current era. It is a backdrop to for understanding and contextually placing the crisis which has developed in social work during the past quarter century, and shifts in social work practice in recent years. The next sections deal with the expansion of a linear-mechanistic, positivist-anchored paradigm in casework from its inception, the expansion of this paradigm, and the development of an alternate ecological-systems, naturalist-anchored paradigm, in a qualitatively different conception of social work practice.

A Linear-Mechanistic Approach
and the Clinical-Normative Model

Some Historical Notes on the development of casework.

The "clinical-normative-individual-system" model of casework (Lutz, 1968, pp. 18-21) reflects its dominant themes since the infusion of psychoanalytic theory in the 1920's and 1930's. The model addresses itself to helping a person with a problem. The notion of "problem" is conceived as "distressful intrapsychic functioning" and "disordered social functioning" (p. 8). A problem is represented by interpersonal or social behaviors which are deviant from a standard cultural or developmental norm. Emphasis is on a person's "sick," *regressed*, internal qualities, addressed mainly in terms of a psychoanalytic personality system. The introduction of modern social theory and ego psychology into practice has seen greater acceptance of cultural relativity, with a diminished tendency to see the client as "sick" but rather as not having achieved developmental norms. For Lutz this model remains tuned to a "culture of sickness," with a bent toward thinking in terms of *illness* persisting among its practitioners.²

The history of the clinical-normative model may be traced to the cultural and scientific ethos of nineteenth century England and America. Casework's origins in that era may be seen through the efforts of various factions of society to establish a "stabilizing" social control, based on internal change or external management, over people whose lives were rendered chaotic by industrialization

and urbanization. These origins may be traced to the Reverend Thomas Chalmers' visitations of the poor in the 1820's and 1830's in his Glasgow parish. Chalmers' approach was delimited by the Calvinist notion of predestination. It reappeared with the development of Charity Organization Societies (COS) in England and the United States in the last quarter of the nineteenth century (Lubove, 1965, pp. 2-5). The approach may broadly be seen as an effort at maintaining stabilizing control over the poor, while overlooking social and economic causes of such distress.³ Early COS workers viewed such changes as transformation of moral character in the individual pauper (deSchweinitz, 1943, pp. 113, 148-53). Lubove (p. 7) sees "scientific philanthropy" as a move toward greater efficiency of nonetheless preconceived moral notions about character, based on the presence or absence of moral fiber that could enable a person to be trained to act responsibly.

With the infusion of moralistic "scientific charity" went the influence of nineteenth century science. The idea was (Germain, 1971, p. 242) that people could be understood by "immutable laws of cause and effect" thought to govern behavior. Sufficient knowledge of the past could lead to certainty for treatment. Richmond's Social Diagnosis (1917) may be seen as a culmination of the application of this doctrine.⁴ As Germain (1971, pp. 243-4) states, casework, heir to COS scientific aspirations, "was deeply rooted in the optimism and scientism of the late 19th century." Diagnosis was seen to emerge "in proportion to the number of facts ascertained (cause) and would point to the treatment steps that

would lead inevitably to cure (effect)." This was similar to the "doctrine of specific etiology" of nineteenth century medicine.

It is no surprise in retrospect, that this tradition's heirs, partly rooted in the Calvinist ethic of predestination and the linear cause-effect approach, embraced the medical model and its psychoanalytic offshoot. As Janchill notes (1969, p. 81), the medical model presupposes a normative appraisal. While Richmond and others used the medical model as a *metaphor*, Germain (1971, p. 251) notes that it was misapplied by her contemporaries and followers in *literal* terms, unaware of its "make-believe aspect."

This literal application of the medical adopted into casework practice in the 1920's (Germain, 1970, pp. 13, 15-16), along with that decade's "conservative social climate" (Woodroffe, 1966, p. 135), laid a foundation for accepting theories which focused on the individual and tended to obscure his social matrix (Woodroffe, p. 146). Woodroffe speaks of the "psychiatric deluge" of the twenties as reinforcing, in the notion of psychological inadequacy, the American individualist conviction that most problems of poverty were reflections of moral inadequacy (p. 135).

Germain (1971, p. 250-7) sees the misapplication of the medical model as having obscured the interaction of individual processes with social processes, and constricted casework's development. Yet, if we review Richmond's attempt to establish an encompassing concept of social diagnosis, although rooted in a mechanistic framework of "scientism," we see effort toward a *holistic* approach based on social causative factors. Thus,

movement to a more holistic view of a case in Richmond's work is paralleled by the search for a more objective-scientific approach, while an underlying (now socio-scientific) determinism remains.

The introduction of a nascent psychoanalytic theory in the 1920's when its final structural format emerged, was followed by its adoption in the early 1930's, "as casework's chief knowledge base" (Hellenbrand, 1965, p. 308). Hamilton, in reaction to the narrower approach of ostensibly treating via personality only, cautioned against the exclusion of economic problems and poverty from social workers' concerns (Hellenbrand, pp. 203-4). We see a re-emerging effort to develop a holistic and organismic approach in the "person-in-situation" (Germain, 1970, p. 19) concept in Hamilton's Theory and Practice of Social Casework (1940). Thus, holism (broader than Richmond's) returns in a normative scientific outlook of what has now become the *diagnostic school*. Determinism (now of a psychosocial variety) remains cachéd in the background.

As summarized by Lutz (1968, pp. 9-14), in the 1950's and 1960's, while interest in the social sciences increased, casework was increasingly influenced by concepts such as organized groups including family or school, roles and communication, and cultural variations in life style. Ego psychology emerged in the forties and fifties, offering a dynamic explanation of the ego's capacity for growth and adaptation, based not merely on the narrower, intrapsychic, mediating function of the ego, but on a broader conceptualization of its ability to interact with the external world.

Pathology is recognized as impaired ego development, or in regression to a prior level of development under stress. The approach is to see the person, through her ego, as responding dynamically to her life situation at a particular time. Help involves development, maintenance, or return of some degree of autonomy to the ego.

The norm is independent functioning of the person. Deviation from it is where pathology lies. The value which appears to underlie the norm is *adaptation*. Ego psychology accepts a high degree of cultural relativity, in that adaptation need not be conformity to (or deviance from) one specific set of norms. Adaptation involves each individual's unique mode of handling and resolving her life's conflicts within the context of her own unique social encounters and internal stresses at particular times in her life.

Ego psychology, emerging from a clinical-normative framework of psychoanalysis, seems to have enabled psychoanalytic theory to develop in a broader, more holistic and organismic direction, and to retain a less stringently normative outlook as it influenced casework. Under its sway, however, determinism in casework (as with Hamilton's earlier developments) remained cached in the background, but grew broader, more psychosocial in scope.

Essentially, major historical developments in casework which have led to the clinical-normative model of today show certain trends. (a) The tendency to react to a relative narrowness of approach during one era is met by attempts to develop more

holistic and organismic approaches. (b) While the normative aspect of theory and practice has become less rigid, it has by no means disappeared. An emphasis on the presence or absence of individual moral fiber from COS days, shifted toward an emphasis on socially determining factors, and then toward attempts at the integration of psychological and social causation. (c) Thus, the concept of causality has moved from emphasis on direct and intrapsychic causality, to interaction of social and intrapsychic, ego-oriented causative factors, in an apparently looser, less rigid framework. Thus, holistically-oriented reactions to a relatively narrow approach during some periods, may be seen as reactions to a simplified notion of linear causality. Yet, the infusion of science into casework has not altered the underlying thread of determinism

In the sixties varied practice innovations emerged (Germain, 1970, p. 22). "The impact of massive poverty alongside affluence, the persistence of social pathologies despite the advances in knowledge, and the the civil rights movements influenced community organization beyond anything experienced by casework or group work" (Germain & Gitterman, 1980, p. 357). Public fund availability to social agencies (including settlement houses and family service agencies), note Piven and Cloward (1971, p. 295), "brought...thousands of voluntary groups into different phases of the anti-poverty effort...." As Germain and Gitterman (1980, p. 352) note, "pressing social issues of the 1960s' and 1970's, including civil rights, the Vietnam War, and the war on poverty ...threatened the role of casework in the profession and in

society." With a broadened return to emphasis on social factors, the dominant model was again seen as too narrow, and a crisis developed.

A basic question at this point is: Why has the clinical-normative model come under increasing criticism? The answer appears to lie in three areas: (a) First, the model does not deal adequately with the conflict between humanism and science. In fact, it perpetuates this conflict. (b) Second, the model remains basically anchored to determinism; and determinism, for science in general, and for casework in particular, has been increasingly problematic. (c) Additionally, from a more pragmatic standpoint, it seems out of place, with current emphasis on social factors as contributory to individual maladjustment, given its implicit placing of responsibility on the individual for his plight. What at an earlier time had been viewed as the fault of the victim, tends now to be seen as relative to impinging social factors.

Germain notes the historic threads of science and humanism in casework's search for knowledge and skill, for a sense of social purpose for humanity, and for professional values in its development (1973a, p. 325). Efforts in the 1820's to utilize scientific principles "in handling the problems of charities and correction crystallized in the commitment to a scientific method known as scientific philanthropy." From this era to Social Diagnosis in 1917 and into the next few decades, casework increased its scientific commitment "by absorbing knowledge from

the behavioral and social sciences, developing a method based on the logical principles of scientific inquiry, and adopting scientific attitudes of objectivity and open mindedness" (1973b, p. 126).

Yet, science and humanism, especially in the 1960's, have often been seen as presenting opposing instead of complementary ways of viewing humans in their world. For example, the application of science has been seen as having dangerous consequences for humanity. "Sometimes this conflict has been called the cause-function issue and sometimes it has been termed the tension between social purpose and technical process." For a profession which engages in human services, this conflict, as Germain indicates, overlooks the need for these two cultures to complement one another (Germain, 1973a, p. 325).

Germain (1973a, p. 325) notes two trends with reference to this conflict. The first is the appearance of general systems theory in the behavioral sciences together with a worldwide "humanist push by individuals and groups...toward active control over their own destinies," to which spirit the application of general systems theory to social work lends itself. The second is a set of ideas which has emerged within the profession. It was espoused by Gordon (1969) after Lutz's (1956) initial application of general systems theory to social work. Gordon blends general systems theory with a concern for human potential to reformulate the person-situation concept in systems terms. For Gordon, social work's expertise lies at the interface between person and environment. Its knowledge base and intervention focus rest upon

people's coping capacities and how to strengthen these, and upon environmental qualities and their melioration. Its purpose is realization of human potential.

Bartlett (1970) elaborates on the concept of social functioning. She focuses on the interaction between people and environment, specifically on "the relation between the coping activity of people and the demands of environment." Unlike earlier emphases on behavior, the attention of this concept is "directed primarily to what goes on *between* people and environment through exchange between them." People and environment are joined in one concept and must therefore be viewed together (p. 116). She emphasizes the importance of humane values, potential and growth, and knowledge derived from social work experience as well as from other fields, in efforts at building a model for practice (pp. 57-61, 62-83).

The need has been apparent for a scientific outlook which encompasses the person-environment unit in a humanistically-oriented value base. It is toward this end that the ecological systems approach and life model may be said to reach.

Determinism and the Clinical-Normative Model.

To understand the place of determinism in the development of casework, we examine (a) the interplay of science and technology, and (b) particular limitations of psychoanalytic theory which has provided a validating scientific framework and philosophy for understanding the individual in the clinical-normative model.

With regard to the first perspective, expanding technology has affected the social order. Germain (1973a, pp. 323-4) cites Toffler's (1971) notions of *transience*, *novelty*, and *diversity*, whose combination strains our capacities for coping, for commitment, and for a sense of reality. For some this calls forth a sense of incompetence, "stress and uncertainty...anxiety, depression...illness, violence, various forms of escape." The poor, who lack environmental supports, suffer most. Institutions designed for resources and services, often inhibit adaptation and growth. Furthermore, as society has become complex, one might conjecture that variables with which to trace cause-effect relationships have become more difficult and less useful to isolate.

The historical trend toward a more holistic view in the clinical-normative model reflects concern that casework may have been defining its own function in too narrow a fashion (Germain, 1973a, p. 323). "Old dichotomies of person-environment and subject-object...man's centrality" are giving way to the scientific and humanistic conceptions of man's inseparability from nature in a delicate, continually adjusting equilibrium which requires "the application of compassionate concern, knowledge and wisdom... [toward] human freedom and autonomy" (Germain, 1973b, p. 128).

With reference to limitations of psychoanalytic theory, Peterfreund (1971) sees Freud's clinical discoveries as revolutionary demonstrations that mental activity, being predominantly unconscious, lacks unlimited free will, and is

subject to universal laws--which changed our views of ourselves and our relationship to the world (p. 94). These laws have presented some serious theoretical problems in Peterfreund's view. One is drive theory's use of "cause-and-effect, linear, one-to-one, sum of parts explanations, such as impulse versus defense, driving force versus counterforce...and so on" (pp. 81, 82). A second problem is the divorce of the psychic apparatus "from biology, neurophysiology, and evolutionary time" (p. 77). Physical and psychic energy are different concepts. Physical energy's transformation into structure is dependent on its quantity. Psychic energy's transformation into ego structure is dependent upon its identity, qualitative character and directional properties (which are not inherent in physical energy), as well as upon the ego (pp. 57-8).

Psychoanalytic theory has provided a psychological base for the clinical-normative model. Yet, for Peterfreund (1971, pp. 61-5, 70), it confuses three conceptual languages. These are the languages of (a) persons, tension and self, (b) psychic apparatus (in a hydrodynamic physics metaphor), and (c) biology and physiology. Hamilton's person-in-situation concept may be seen as an effort to develop a broadened, psychosocial view of helping. The person presents psychological and biological aspects, and the situation presents social and physical views (Rapaport, 1959b, pp. 63-6). Yet, determinism remains embedded in a model whose languages seem to present problems of compatibility.

Some Psychoanalytic Influences

Historical Precursors and Conceptual Introduction.

Freud's *topographical theory*, which explains man in terms of levels of consciousness, emerges with "The Interpretation of Dreams" (1900/1953). He describes psychosexual stages of development and libido theory in "Three Essays on the Theory of Sexuality" (1905/1953). During the next two decades, in case histories and other papers, he develops his ideas in clinical work. "Inconsistencies between [topographical] concepts and clinical observation" led to a reorganized *structural viewpoint* in "The Ego and the Id" (1923/1961)--seen by Jones (1957, Vol. 3, p. 87) as the origin "of the new psychology of the ego." Id, ego and superego supplement and conflict with one another. The latter two possess conscious and unconscious aspects (Glenn, 1980, p. 6).

Conceptions of the ego will be explored from the complementary vantage points of its mediating-defensive functions, and its adaptive and synthetic functions. The *first* deals with the metapsychology of intrapsychic conflict. The *second* deals with resources and demands of the environment, through the individual's relationship to his world of people, things and events, and his sense of unity and continuity.

From Mediating-Defensive Functions to Conceptions of Adaptation.

In "Inhibitions, Symptoms and Anxiety" (1926/1959) Freud presents the concept of defense in its current form as several

processes which protect the ego from instinctual demands (A. Freud, 1936/1966, p. 43). As Rapaport notes (1959a, p. 10) Freud, in that paper, sets a cornerstone for an ego with some independence from the id, which through constitutionally endowed perceptual and affective mechanisms is autonomously active in curbing drives whose derivative behavioral actions could lead to danger in external reality, by initiating defenses through the signal of anxiety. Thus, *external reality* is made a part of theory while the role of instinctual drives remains intact.⁵

In this context, Anna Freud in The Ego and the Mechanisms of Defense (1936/1966, pp. 54-61), presents a summation of defense mechanisms according to their sources of anxiety: objective, instinctual and superego-derived, plus the ego's later-in-life need for synthesis. As noted by Young-Breuhl (1988, p. 209), Anna Freud thereby describes the correlation between various defense mechanisms and psychopathology, and also draws "a rough map of defenses in normal development." By her "concept of defense against external stimuli" (Rapaport 1959b, p. 11), she integrates the themes of defense and reality relations.

A firmer place for the role of reality comes with (a) Freud's conception of secondary process and the reality principle, in his "New Introductory Lectures" (1932/1964); (b) what Rapaport (1959a, p. 11) refers to as "inborn ego roots" (predisposition, sic) which are "independent of instinctual drives," as an explicit assumption in Freud's "Analysis Terminable and Interminable" (1937/1964);

and (c) the development by Freud (1926/1959), Nunberg (1931), and Waelder (1936) of an autonomous, synthetic ego function.

The development of ego psychology, as recounted by Rapaport (1959a, pp. 5-10, 11), is next "dominated by contributions of Hartmann [on adaptation] and Erikson [on epigenesis and identity]," built upon Freud's groundwork in ego psychology and psychosexual development.

Hartmann (1939/1958)⁶ builds on Freud's later assumption of drive-independent inborn ego roots in Ego Psychology and the Problem of Adaptation . He postulates an inborn, undifferentiated id-ego common root, out of which both structures differentiate and begin to interconnect with one another (pp. 102-3).⁷ He describes the newborn as not wholly dominated by drives, given inborn perceptual and protective mechanisms which, after the the ego and the id differentiate, are attributed to the ego (p. 49). It is relative to an "average expectable environment" (p. 51) that "a state of adaptedness exists before the intentional processes of adaptation begin" (p. 49).

Underlying the concept of adaptation for Hartmann is the observation that "living organisms patently 'fit' into their environment [and]...adaptation is primarily a reciprocal relationship between the organism and its environment" (Hartmann, 1939/1958, pp. 23-4). Man can actively utilize his inborn and maturing apparatuses toward improvement his relationship to the environment" (p. 25). Hartmann observes man's capacity to comply with environmental demands (autoplastic adaptation), to

change his environment to meet his needs (alloplastic adaptation), and to choose new environments. Thus, "human action adapts the environment to human functions, and then the human being adapts (secondarily) to the environment which he has helped to create" (pp. 26-7). Hartmann specifies social structure, division of labor and the individual's social locus as codeterminants of the parameters of adaptation (p. 31).

Ego functions of primary autonomy develop to maturity in a conflict-free sphere, independent of the influence of drives. These functions include perception, memory, intelligence, thinking, motor-activity and reality-testing. Ego functions of secondary autonomy may differentiate and develop, or be overtaken in regression by the id, through conflict. In Hartmann's widened perspective on the ego, defenses themselves may *simultaneously* serve the functions of "control of instinctual drive, adaptation to the external world...and synthesis." An examples is identification with the aggressor (Hartmann, 1939/1958, pp. 22-37, 48-56, 51).

In discussing mental health, Hartmann specifies that "normal development involves typical conflicts, and with them the possibility of adaptation disturbances." A measure of mental health is a person's "preparedness for *average expectable* environmental situations, and for *average expectable* internal conflicts" (1939/ 1958, pp. 54-5).

Rapaport (1959a, pp. 12-14) notes that Hartmann (1939/1958, 1952), and Hartmann Kris and Lowenstein (1946), via concepts

which include ego apparatuses of primary and of secondary autonomy, automatization, neutralization and binding of psychic energy, provides the metapsychological foundations for Erikson's epigenetic, psychosocial theory of development. Erikson, in Childhood and Society (1950), and in "Growth and Crisis of the Healthy Personality" (1959a), calls on the *epigenetic approach*. It is a model for embryonic development "transplanted" from "the chemical exchange of the womb" to "the social exchange system" of society, in which one's "gradually increasing capacities meet the opportunities and limitations of...culture." A healthy child with reasonable guidance, "can be trusted to obey inner laws of development, laws which create a *succession of potentialities for significant interaction* with those who tend him." "Such interaction must remain within the proper *rate and the proper sequence* which govern the *growth of a personality* as well as that of an organism." Through the predetermined steps of an inner "groundplan," the human organism attains "readiness to be driven toward, to be aware of, and to interact with, a widening social radius, beginning with the dim image of a mother and ending with...that segment of mankind which 'counts' in the particular individual's life" (Erikson, 1959a, p. 52).

At each interval, potential is unlocked for the psychosocial mastery of progressively more inclusive developmental tasks in each of the eight successive stages of the life cycle. A stage is marked by its ascendance prior to its "decisive critical time,"

followed by a crisis in which the individual "is ready for a [mutually reciprocal] *decisive encounter* with his environment" to find an enduring "solution...*toward the end of the period.*" "Each stage," adds Erikson from a metapsychological perspective, "becomes a *crisis* because incipient growth and awareness in a significant part function [of personality] goes together with a shift in instinctual energy...and causes specific vulnerability in that part" (1959a, pp. 53-4).

Erikson (1950, pp. 44-92; 1959b, p. 121) conceives his first five stages of development as inseparably dovetailing with Freud's respective five psychosexual stages from infancy through puberty. These are followed, for the first time in psychoanalytic theory, by the three stages of adulthood. For Erikson (1959b) development is a lifelong process in which later crisis resolution can have compensatory effects on earlier problems (Goldstein, 1984, p. 9). Such effects emerge most pointedly around the issue of identity.

It is through the healthy personality that Erikson presents human growth. The healthy personality weathers internal and external conflict, "emerging and re-emerging with an increased sense of inner unity...good judgment, and...capacity to do well, according to the standards of those who are significant" (1959a, p. 51) and a preconscious "sense of psychosocial well-being" (1959b, p. 118). This contributes to a sense of *identity*, a central concept in Erikson's work (Roazen, 1976, chap. 6). Identity formation rests on the outcome of each successive stage

(Goldstein, 1984, p. 10). Identity is presented by Erikson both as a psychosocial phenomenon and as a metapsychological concept known as ego identity. It is more than the sum of childhood identifications. "It is a lifelong development largely unconscious to the individual and to his society" (1959b, pp. 112-13). It is represented in the "tentative crystallizations" of childhood, which result in a person's feeling and behaving as though he more or less knew who he was in the series of tentative identifications which begin to build expectations which then become "verified decisive experiences of 'psychosocial fittedness'" (1959b, p. 114). The ego, for Erikson, must integrate "psychosexual and psychsocial aspects on a given level of development," while it also integrates new identity elements to those which already exist. From a metapsychological viewpoint, "earlier crystallizations of identity can become subject to renewed conflict, when changes in the quality and quantity of drive, expansions in mental equipment, and new and often conflicting demands...make previous adjustments appear insufficient...." The process of growth emerges from such "developmental and normative crises" and "provides new energy, as society offers new and specific opportunities." Thus, identity formation is "an *evolving configuration*, established gradually through successive childhood ego syntheses and resyntheses of "*constitutional givens, idiosyncratic libidinal needs, favored capacities, significant identifications, effective defenses, successful sublimations and consistent roles*" (1959b, pp. 115-16).

Erikson remains true to his psychoanalytic theoretical base (and professional birth with Freud) in the presentation of his psychosocial viewpoint as an elaboration of Freud's developmental view, along with formulations which integrate his theory with psychoanalytic metapsychology (Erikson, 1959b, p. 121; Roazen, 1976, pp. 1-3, 20).

White (1963, p. 19) describes Erikson's view as the first "to do justice in more than a schematic way to both the processes of inner development and the influence of social and cultural surroundings." He elaborates that Erikson sees Freud's view as narrow "in terms only of pleasure seeking and erogenous zones." Erikson's broader concept of *modes* is seen as referring to generalized motor and cognitive behavior patterns. "Zone and mode are all of a piece, so to speak."

As Goldstein (1984, p. 10) notes, Erikson has provided "rationale for therapeutic approaches that address the dynamic interplay between current life cycle needs, and...inner and outer resources," including "notions of primary prevention through interventions aimed at improving adaptive fits between caretakes and children, as well as between individuals and environmental resources."

Some Interpersonal Conceptions.

Sociologist Talcott Parsons (1964) presents structural theory and object relations as prominent in Freud's later thinking. The former is seen as representing the organization of personality as a differentiated system, while the latter is seen as dealing with the relation of the individual to his social milieu. Parsons (p. 34) in an overview of Freud's conception (1923/1961) of the ego, refers to the ego's structure a "precipitate" of the individual's history of object relations. He speaks of *identification* as the process of a person's induction "into membership in a collectivity through learning to play a role complementary to those of other members in accord with the pattern of values governing the collectivity." (p. 42). He sees Freud's theory of object relations as a formulation about socialization, (p. 34) "an analysis of the relation of the individual to the *structure of the society*" (p. 52), centering mainly on the earlier phases of the socialization process (p. 34).

Guntrip (1973) distinguishes two groupings of Freud's ideas: The first is the id-plus-ego-control apparatus, which includes Hartmann's autonomous ego and its apparatuses (p. 28). He sees Hartmann as having extensively developed the more impersonal, mechanistic aspects of Freud's theory (pp. 28, 43, 51-5, 104-11), wherein "steadily developing human and personal phenomena [are confined] within the straightjacket of prepersonal biological concepts" (p. 109).

The second, grouping is referred to as "the Oedipus complex of family object-relationship situations" (Guntrip, 1973, p. 28). It is a sort of personal psychology of people's influence on one another's lives, notably parents and children. The internal process of secondary identification soon takes the place of a child's early, actual Oedipal relations with parents. We may broadly say that it is the emphases on (a) the child's introjection of the theatre of characters, (internal objects) and (b) his development of a capacity to relate to these characters that distinguishes the object relations school from the classical ego psychological theory. Yet, as described by Guntrip (pp. 19-44, 45-68, 69-102), this approach, integrates with concepts from ego psychology. It revolves around the person-ego (as opposed to an impersonal ego structure) found in the work of Fairbairn, Winnicott and Erikson, and sees the very beginnings of ego growth as the core of selfhood, and "bound up with the first and fundamental object relationship, that of the mother and her baby" (Guntrip, p. 21). Guntrip summarizes Winnicott's subjectively oriented descriptions of "a continuously helping, fostering, nurturing environment, accepting the infant's immature dependence while supporting his tentative adventures into independence, individuality, and finding a life of his own... through personal relationships" (Guntrip, p. 113). Implicit is a recognition of the influence of *reciprocally* attached caretakers in early development.

Sullivan's interpersonal psychology, developed as "his own independent insight," apart from the personal influence of Freud and his direct followers (Guntrip, pp. 46, 45-68; see, Chapman, 1976, pp. 28, 223-42), has as a fundamental premise the notion that anxiety originates in the interpersonal encounter--rather than within the psyche (Sullivan, 1953, pp. 10, 8-12, 41-5; Chapman, pp. 81, 78-86). It may thereby be said to enshrine, as most basic to human existence, the reciprocal effect that human beings have upon one another. A number of Sullivanian concepts have approximate Freudian counterparts. Sullivan's developmental eras and zones of interaction broadly parallel notions of Freudian psychosexual development. Sullivan presents his own distinctive underlying, biology-derived, interpersonal premise which he has woven into his views, namely that "the living cannot live when separated from...their necessary environment." This is his "principle of communal existence" upon which all living processes depend (1953, p. 31).

Guntrip (1973, p. 43) sees Sullivan and Erikson as having explored "the growth of the individual ego in its ever-widening social milieu." We also note Guntrip's point (pp. 43-4) that of the two strands in Freud's thought (a) the natural science/physiological/mechanistic, *and* (b) the psychodynamic/personal/object-relational, "it was the latter that was struggling [with success in the post-Freudian era] to break free and develop in its own right."

The Realm of Competence and Action.

Robert W. White (1963, pp. 16-17) writes about the state of ego psychology after Freud's death. In a discussion of Hartmann's notion of autonomous ego development, White notes that Hartmann adheres to Freud's concept that neutralization of instinctual energies allows the ego to have independent energies. By his explanation of ego autonomy through the principle of neutralization Hartmann does not challenge Freud's instinct theory.

White (1963, p. 18) goes on to say that others saw the problem of ego energies as requiring "a more revolutionary solution." He speaks of Hendrick's (1942, p. 51) *instinct to master*. It lies in a proposed "basic psychobiologic urge of human beings to control as large a segment of the outer world as is compatible with their individual limitations and those imposed upon them [and] is manifested in early infancy by the exercise of rudimentary sensori-motor functions...." Hendrick adds that pleasure is derived from this instinct through effective use of sensory, motor, and intellectual functions, physiologically available. For Hendrick (1942, p. 40), it is an "inborn drive to do and to learn how to do." In an extension of this thinking, Hendrick (1943, p. 327) formulated a "work principle" which is the need to derive pleasure through integration of neuromuscular and intellectual functions. Work pleasure is not, however, primarily displaced or sublimated sexual pleasure. It is, rather, "an expression of an instinct to master."

Kardiner and Spiegel (1947) propose an "effective ego," which, as White (1963, p. 18) states, has no hypothesis about energy sources. In an effort to conceptualize the development of wartime traumatic neuroses, Kardiner and Spiegel replace the term "instinct" as the operational unit, with the notion of "action system." They study how activity in relation to the outer (as opposed to libidinal) world is integrated (Kardiner & Spiegel, pp. 257-8). Along with active and passive modalities of adaptation, they propose a third type of adaptation which is based on the possibility that an organism can be overwhelmed and destroyed by events in the outer world; but can remain intact and continue its life by altered adaptive maneuvers through "actions systems." These become integrated in order to maintain "controlled contact" with, and "controlled exploitation" of the outer world (p. 260).

White (1963, p. 18) cites Mittelman's proposal (1954, pp. 159-61) of a partial instinct or motor urge of "motility" which is dominant from the second year of life for several years. "Motility" is proposed as a basic means of reality testing and integration of the period, and as directly related to the development of assertiveness and self-esteem.

Drawing on the work of Hartmann, Erikson, Hendrick, Kardiner and Spiegel, and Mittelman, Robert White (1959, pp. 328-9) developed his concept of *competence*. It grew out of an effort to deal with the inadequacy of psychoanalytic theory to explain, on the basis of primary drives, exploratory behavior,

manipulation and general activity, as well as the effective ego. White (1963, p. 42) proposes a conception of an "independent ego energy" which is neither part of the libidinal nor aggressive instinctual drives, are not themselves referred to as drives, and yet are just as primary and "as basic as anything in human nature, and...have a clear significance for survival" (p. 24). These energies, termed *effectance*, inherent in the apparatus of the ego, are found in satisfying, exploratory and manipulative behavior, which maintain and expand interaction with the environment, and which result in an "effect" (pp. 36, 38, 42). These energies "prompt the child to keep trying out the effectiveness of his ripening capacities for action" (p. 33).

The stimulation, action, effort and production of effects are, together with a *feeling of efficacy*, "a primitive biological endowment as basic as the satisfactions that accompany feeding or sexual gratification, though not nearly as intense" (White, 1963, p. 35). White (1963, p. 37) draws on the ideas of many, including those of Murray and Kluckhohn (1953, pp. 15-16,) who see the infant as occupied with pleasure and gratification.

Competence is a person's objective current capacity to interact effectively with his human and physical environment. It includes some innate abilities, but is mainly and cumulatively a result of learning in transaction with the environment. (White, 1963, p. 39)

One's *sense of competence* describes the subjective side of one's actual competence. It describes the "accumulated and organized consequences" of a history of feelings of efficacy as these are experienced in each transaction (White, 1963, p. 39).

In "Competence and Psychosocial Stages of Development," White (1960, pp. 108-21, 137-8) takes the reader through Freud's (libidinal) psychosexual stages and Sullivan's (interpersonal) eras of development, along with Erikson's first five stages of the life cycle. He proposes the supplementary addition to a psychoanalytic developmental view, a conception, at each level, of the growth of the child's capacity for action and for understanding, in addition to libidinal and interpersonal conceptions. Thus, for example, effectance and competence would be seen as "oral" "manipulative prowess and experimentation," or as an "anal" crisis in social competence and in the growth of motility.

Gladwin (1963) believes that it is vital that someone seeking help learn "ways of acting" which are "useful and effective" in supplanting maladaptive ones. This may be done through the "many potential sources of strength which could be available to the individual person through a variety of larger social systems," "in the setting in which the behavior arises and in which its impairing effect is felt" (p. 31). For Gladwin, competence is seen as developing on three interrelated axes. The first is an "ability to learn or to use a variety of...pathways or behavioral responses in order to achieve a given goal," and to choose instrumental and

ultimate goals. The second is a comprehension of and ability "to use a variety of social systems within the society, moving within these systems and utilizing the resources they offer." The third is a capacity for "effective reality testing" which includes a "positive, broad, and sophisticated understanding of the world" (p. 32).

For Gladwin (1963), the modality through which the experience of competence is achieved is a setting known as the "ecological unit," which encompasses in one system the person and whatever part of his social environment pertains to the behavior which is being considered (p. 32). In times of stress, it is what he calls the "small ecological treatment unit," (which might include group discussion and support) that holds forth a possible strategy for reversal or prevention of pathological behavior, through the "improvement of personal competence" (p. 34). Change can also be effected in intermediate ecological units (such as organizations) to help individuals affected by these organizations, by a process of changing the functioning of its members or the functioning of the system itself (pp. 34-5).

Some Family Practice Themes from Casework and Psychiatry

Early Themes.

Richmond (1917, p. 136) recognized family as central in individual treatment so that "the first interview is often held in the client's home and with members of his family present." While maintaining a focus on *the client*, she suggests (1922, p. 138) that a next step for casework is to bring together with the client "those to whom he is socially related" for first-hand observation.

Historically, says Hamilton (1951), the family field had been concerned with "maintenance and conservation of family life" which could be threatened by "*lack of income...handicaps and asocial behavior of its members*" (p. 124). While social insurance and assistance provided for the former, the latter had been handled by voluntary agencies such as child guidance and marriage counseling clinics, churches, public schools and courts. She sees family counseling as a main function of a family and children's agency (pp. 124-5), and affirms the centrality of family in practice. "Most casework problems are interpersonal...more than one person is likely to be involved in the treatment of the individual, and particularly in casework is the family unit involved" (p. 22). She cautions against separating family work with parents from "children's work" in the "child centered case" (p. 49).

Hollis (1964, pp. 174-5, 193) advocates selective use of joint interviews with client and spouse or an entire family, as well as home visits and a family profile for diagnostic clarification.

Sherz (1953), in discussing family-centered casework, notes the inadequacy of trying to understand a person out of context from those with whom he has close emotional ties. This could involve seeing more than one member of a family. Her subsequent emphasis (1962) is clear as to the value of a focus on the entire family, so as to adequately understand and work with particular members' problems. She accepts a selective combination of multiple and individual interviews, as needed.

Sherz (1959/1963) lays out basic issues for casework assessment and treatment related to family interaction. It is axiomatic that a person and family form one interactional field, and that to be helped effectively both must be understood in their dealings with one another. "A growing point of view" is that all casework "should be family focused" (pp. 129-30). She outlines the utility of integrating "cultural aspects into concepts of family interaction" (p. 130). With reference to Spiegel (1958) Scherz (p. 131) notes that "some cultural value orientations are learned in childhood only through their indirect impact on conscious behavior and are, therefore, 'behavior without awareness,'" in the form of cultural values which influence individual and family values. She emphasizes the intertwining, mutual influences of the individual's ego developmental tasks and family development (pp. 132-3). She focuses on the consequences of breakdown in family interaction and patterns of communication (pp. 133-8), as well as on the value of home visits and joint or multiple office interviews for assessment and treatment (pp. 138-44). Sherz introduces these conceptions by

noting their origins in casework practice, as well as in a cross-fertilization between casework and psychiatry (p. 129).

As recounted by Guerin (1976), the family movement in psychiatry begins in the late 1940's and early 1950's, with relatively independent developments in different areas of the country. Major thrusts emerged from (a) frustrated efforts "to apply conventional psychiatric principles to work with schizophrenic families," and from (b) efforts to deal with behavior problems and delinquency in children (p. 3). Some early family therapists emerged from child guidance and psychoanalysis. Bowen (1975, p. 368) notes that the psychoanalytic principle of the privacy of the treatment relationship (to prevent contamination of the transference by a therapist's contact with a patient's relatives) would split the treatment of a hospitalized patient and family members among different therapists, and may account for the family movement's early "underground" status in psychiatry.

As described by Haley (1971a, pp. 1-7), early notions coalesced around joint observation of the entire family rather than use of reports by one person. This led to interventions being geared to change ways in which members of a family would deal with one another. Family therapists began to think of a psychiatric problem as an expression of a family problem, and saw a need to reconceptualize the work. Yet, since no theoretical model existed for this, notes Haley, therapists struggled to find a theory which would fit their practices. He cites efforts of practitioners into the 1960's with varied emphases, including work

with diads, triads, extended kin and social context, and ecological networks; use of varied orientations including role theory, information theory and systems theory; and the treatment of families in moments of crisis.

Olson (1970, pp. 503-4) presents an overview of pioneering efforts of practitioners whose disillusionment with individual approaches to treatment moved them to a focus on the family rather than on the problem child, who is seen only as a symptom of a broader family pathology. Walsh (1983, p. 467) cites three pioneering investigations of the 1950's which involved observation and conceptualization of whole family processes. The investigators included Lidz and colleagues, at Yale; the NIMH teams of Bowen and colleagues, and Wynne and associates; and the Palo Alto group of Bateson and others. "These investigations," says Walsh, "all attended to ongoing, repeated transactional patterns. Regardless of origin, patterns were observed to operate currently in cycles that maintained or reinforced disturbed behavior in the identified patient. A complex circular chain of causality was seen to connect the actions and reactions of all family members."

As Guerin notes (1976, p. 7) the late 1960's and early 1970's saw "an intensified ideological war between analysis and systems people." Battles focused on such issues as "the sanctity of the transference, and the necessity of the concept of the unconscious." In 1971, with the death of Ackerman, the family movement's "most creative and zealous psychoanalytic proponent...the center of the field moved swiftly toward systems."

A Coalescing.

Beels and Ferber (1969, p. 285) note that the "definite and agreed-upon purpose" of the treatment relationship among family therapists is to effect "changes in the *system* of interaction, not... in the behavior of individuals." Change in the individual is seen "as a by-product of system change." The therapist's commitment is to a family's functioning, before that of individual members. The therapist is, however, seen as working to promote family growth and differentiation.

Beels and Ferber (pp. 285-301) delineate broad and overlapping clusterings of family therapists according to style. Those who tend to lead and directly control the treatment are viewed as *conductors*. Those who allow themselves to be caught in it, and then utilize their inclusion in the family web as material for understanding and treatment, are seen as *reactors*. Reactors seem to gain entry in a more complex and less direct manner than do the conductors. Reactors-analysts are described as working in various ways with psychoanalytic conceptions. *Systems purists* (also reactors) do not subscribe to these tenets, and are aligned only to systems principles. Membership in these groups seems more related to therapists' styles than to a background presence or absence of a psychoanalytic orientation.

For Olson, (1970) the systems approach has challenged many assumptions by focusing on the person in his live situation, rather than out of his environmental context (p. 504). While he cites important conceptions of kin networks, teams and multiple family

groups (p. 514), Olson points to systems theory as the most vital contribution to family therapy. The individual is seen as an open system, relating to others in the family system which has a quality of wholeness and responsiveness, and which may be understood through communications and transactions (pp. 517-20).

The GAP Report of 1970 on "The Field of Family Therapy" (pp. 565-6) describes family theory as combining "two bodies of knowledge: personality dynamics and multipersonal system dynamics." The integration of these two levels is seen as a distant goal. It further notes that some proponents emphasize the transactional or multipersonal level "as a replacement for rather than an addition to our knowledge about the individual system level or mental organization."

Jackson (1969) advocates that psychiatry shift to viewing the individual in the larger context. He outlines the principles of systems theory, its suitability to the interpersonal context, and its reorganization of world view in relation to causality. To Jackson, this view does not deny the value of individuality and subjective experience, but does emphasize "a new dimension in the study of human behavior, an interactional perspective which all who would involve themselves in the affairs of mankind have a responsibility to recognize. Attention to the individual in the extreme is artificial and cannot be the basis for realistic actions" (p. 395).

Haley (1971b) points to a number of premises which family therapists seem to share "about human problems and the nature of change despite the fact that they work with families in quite

different ways" (pp. 227-8). The premises include conceptions which are strikingly similar to those of the ecological approach. These include (a) the view of family therapy as an orientation to human problems rather than simply a method; (b) primary focus on interpersonal interaction over focus on the individual; (c) more emphasis on the present and less on causal factors; (d) diagnosis as being less extensive rather than a long, formal procedure; (e) the therapist viewed as part of the diagnosis; (f) emphasis on the positive direction in which conflicts must move as opposed to interpretation of hostility; and (g) greater emphasis on problem definition over formal method as key to the work (pp. 228-34).

Auerswald (1969, pp. 373, 373-86) joins the "small but growing group of behavioral scientists who advocate a realignment of current knowledge and reexamination of human behavior within a unifying holistic model, that of ecological phenomenology," whose implications for psychiatric treatment and human services he outlines. Auerswald (1971, pp. 267-8) speaks of the linear and the ecological as contemporary forms of thinking which, broadly speaking, represent the pre- and the post-electronic generations. He declares that techniques are needed in family therapy to bridge the generation gap produced by this social mutation of younger people's thinking. In a description of an ecological view of family work, he proposes an "intersystems conference" at a convenient site, of all family members and related persons from various other systems "who have issued a call for help," or who have "an interest in the family or its members" (1971, p. 277).

Sherz (1970), with reference to social casework, discusses the theory and practice of family therapy. Family is "the unit of investigation and treatment." As a system, it is seen as two or more units relating to each other so "that if there is a change in one it affects the other and the reaction of the second in turn affects the first." It is "a regularly interacting, interdependent system forming a unified whole, transacting life events among its members" (p. 223). As an "open ended system," "members enter and leave" during its life-cycle. Each family system has its unique "biological, cultural and social forces, with its own recognizable role formations," patterns of behavior, communication, emotional reactivity and coping, as well as being unique in its values and modes of relating to its larger social community. As a gestalt, it is "larger than the sum of its parts" (p. 224). When a couple's marital projection system stabilizes into an equilibrium, it becomes self-perpetuating in its behavioral and affective expressions (pp. 226-7). Family developmental tasks are seen as paralleling those of its members (p. 229). "Rules, roles, identifications, alliances and collusions" emerge in communication patterns and represent the family structure (p. 236).

Some influences of systems theory through casework and psychiatry in conceptualizing family therapy, and in the direction taken by family treatment in social casework have been briefly sketched. These influences both reflect and integrate with holistic, ecological thinking as it has developed at the direct practice level of social work.

Some Group Work Themes and Influences:

Historical and Conceptual Notes

The roots of contemporary group work are found in the latter nineteenth and early twentieth century settlement, youth service agency, recreation and adult education movements (Reid, 1981, pp. 45-102). Early *settlements* in America were dedicated to the welfare of immigrants served in their own neighborhoods (pp. 53-5). The early *youth service agencies*, such as Y's, Scouts, Boys Clubs and Jewish youth agencies were usually local endeavors (p. 63), which served to fill leisure time with new interests and to provide "protection against the problems created by inner city life in a rising industrial society" (p. 62). By the turn of the century, in the debate about the choices of large-scale or small group activities, Reid notes that a conviction was growing "that it was better to work intimately with a few rather than superficially with many," to help the individual effect positive life changes in a group process of joining with others toward common ends (p. 73).

The *recreation movement*, which included social workers, encompassed development of parks and playgrounds, use of schools as social centers, and recreational youth organizations such as 4-H, campfire girls, and fraternal and youth organizations with cultural and religious commitments (Reid, 1981, pp. 91-6). The functions of the *adult education movement* were (a) educational remediation, (b) occupational advancement, (c) "relational"

improvements, including parent-child education, (d) pursuit of wider interests, and (e) political orientation to influence social reform in the progressive era (pp. 96-100). By the end of the 1920's, group process and direct member participation in both the adult education and recreation movements were seen by 1920 as means of enhancing problem-solving and social skills, providing support and enrichment, and preventing "delinquency and social maladjustment" (p. 101).

Moralistically, much early practice assumed that character components "could be taught" in specific learning, regimentation, competitive sports and playground activities. In reaction, with Grace Coyle's influence in the 1930's, Dewey's ideas of progressive education were introduced (Reid, 1981, pp. 112-15). In a discussion on the collective thinking process, Coyle (1939, p. 79) sees the need for a consensual instrument, such as agreed-upon assumptions which may change, "through which the group puts its purpose into action."

The group was an established service modality by the mid-twenties (G. Wilson, 1976, p. 15). Neighborhood centers became sociologists' laboratories for building a conceptual language to describe a group and its activity--so that by the early 1930's workers were using terms such as "*purpose, structure, social process, status and role, and stages of group development.*" Social psychology concepts such as *acceptance, rejection, conflict* and *control* were common (p. 17).

By the late 1930's, concern for method had evolved into group work training in social work schools, the start of a professional association, and the incorporation in 1935 of a Group Work Section of the National Conference of Social Work (G. Wilson, pp. 16-17, 19-22).

In the 1940's, group work's alignment with social work grew clearer as its foci on *both* human relations and program elements were clarified by Coyle (1946, 1947), Cohen (1947) and others, to distinguish it from recreation. It increasingly entered social work related agencies such as children's institutions, hospitals and churches. In 1946 the American Association for the Advancement of Group Work was reconstructed into the professional social work association known as the American Association of Group Workers (Reid, p. 145).

As Reid (1981, pp. 132, 155-63) points out, the sociologist Bogardus in his 1930's writings, shaped the idea of therapeutic ends for group work. From the "activity group therapy" of Slavson, in the mid-thirties, along with child guidance work of Redl, Konopka and others, group work had expanded into psychiatric hospitals by the late 1940's. Literature from the late forties to the mid-fifties included Wilson and Ryland's Social Group Work Practice (1949) which combined knowledge in social science, psychiatry, social work method and record-keeping, and the use of media in problem-solving and in individual and group development. Konopka (1949, 1954) dealt with use of group work

method for disturbed children, unwed mothers, the "aged," and prisoners. Klein (1953) in valuing the transmission of culture, role of the agency, and selective use of home visits, saw group work as imparting democratic concepts, and social responsibility to educate people in their roles as citizens. Philips (1957), with an emphasis on the nature and use of group work skills, stressed the utility in society of mutual, interdependent cooperation.

From 1959 to 1963, deliberations of the Group Work Section of the NASW Practice Committee on the nature of social group work led to an understanding of areas of difference between group work and other social work methods. These include group methodology, differential use of common bodies of knowledge (with emphasis on social psychology and group dynamics), emphasis on program media and service systems (over sociocultural notions of society and personality). There was also the view of a different group work emphasis in defining some purposes of social work. This included "the restoration of personal and social dysfunctioning, the prevention of social and personal breakdown, the promotion of normal social growth, especially in stress periods, and the provision of opportunity for personal enhancement and citizen participation" (Reid, p. 185). While the "purpose, focus, goals and sanction of the service" are affected by its setting and the people it serves, notes Reid (1981, pp. 183, 183-9), the group method of practice remains basically the same.

In response to the Committee's study, Schwartz (1964) described what he saw as three models of group work practice,

while Rothman and Papell (1966) subsequently identified three models, each emergent in response to service needs. These are summarized as follows. (a) For Schwartz, the *medical model*, seen as akin to Rothman and Papell's *remedial model*, focuses on investigation, diagnosis and treatment of a problem. (b) His *organic system*, similar to the *reciprocal model* found by Rothman and Papell, conceives a "network of reciprocal activity" for an entire situation. (c) Schwartz notes a *scientific model*, which resembles problem-solving steps in science; while Papell and Rothman describe a *social goals model* whose purpose resembles that of community organization (Reid, 1981, pp. 189-90; Northen & Roberts, pp. 370-1).

The Encyclopedia of Social Work (1971) presents differences which become blurred between (a) the *preventive and rehabilitative approach* of Garvin and Glasser (1971, pp. 1263-72) (b) the *developmental approach* of Tropp (1971, pp. 1246-52) and (c) the *interactionist approach* of Schwartz. (1971, pp. 1252-63) Northen and Roberts (1976, p. 371) found a comparative analysis of approaches represented in several divergent, contemporary papers to be rather difficult.

Reid (1981) summarizes that "on a continuum, there are two polar views, with various people taking stands at stages in between." (p. 191) The extreme of (a) *the preventive and rehabilitative approach* (also known as the *remedial*, or *organizational model*) focuses on the "formed" group as a means by

which the worker can meet specific, studied and diagnosed operationally definable goals for each "selected" member. Social and cultural norms stipulate the criteria with which to describe problem behavior and expected degree of change (pp. 191-2, 193-5). Proponents of (b) the *interactionist* (or *reciprocal*) approach see themselves as humanist and existentialist, and view the group as "a system of mutual aid wherein the worker and the members are engaged in the common enterprise of carrying out the group goals" (p. 191). They conceive a helping process which serves "both the individual and society," by mediating needs of both, in an organic, "symbiotic" relationship (p. 195). A reciprocal relationship between member and group is assumed, with the worker serving as mediator and enabler in "the convergence between client need and agency service" (p. 198) toward correcting and preventing relationship imbalances. Rehabilitation, service provision and prevention are included. Attention is focused on relational processes over outcomes. Current functioning rather than diagnosis is the basis of assessment. Agreement on mutual identification of common ground, obstacles, interests, expectations ("vision") and "contracts" is central to assessment and intervention (pp. 195-9). The basic compatibility of a systems framework with Schwartz's (1976) approach is evident when he speaks of the capacity inherent in systems terminology (p. 181) for an active, reciprocal view. He states: "The model of the open, organic system offers us the opportunity to put together all the

dimensions we need into an image of the helping relationship in action" (p. 180).

In Tropp's *developmental approach*, as in the interactionist view, the group as a microcosm of society is a means through which people help one another in their growth and development. Emphasis is on natural growth processes. The group gives members and worker an experience of authenticity in communication through effective task performance. Assessment embraces the group and the individual (Reid, 1981, pp. 199-200).

Reid (1981, pp. 202-5) cites the *social goals approach* as resembling community organization methods in its effort to deal with problems related to the social order and to social value orientation. The foci are social consciousness and responsibility, with the worker having responsibility for their cultivation. Group work services are conceptualized at the community level, of which the agency is an integral part. The worker facilitates group process, so as to free the members and their group process to facilitate change.

We have seen emergent themes of mutuality, interdependence and interaction, as well as incorporation of an open systems approach, and emphasis on natural growth processes. In addition to the focus on the collective, there is a recognized place for the individual and for the larger community in group work theory.

An Ecological Systems Approach and the Life Model

Some Historical-Theoretical Notes on Systems Conceptions.

Systems theory, as an alternative to the linear-mechanistic approach, presents possibilities for more holistic and organismic theory and practice than its predecessor on two counts. First, it makes a break with mechanistic notions of causality. Second, while norms do not disappear--a model must have norms to operationalize its value base--the systems approach treats norms from a relativist perspective, based on the state of a system at a particular time.

Bertalanffy (1968, p. 11) traces the emergence of general systems theory to Kohler's contribution to Gestalt psychology in the 1920's, which dealt with inorganic "gestalts". Its major axiom is that the perception of an object is determined by the configuration or context of which it is a part. A perception is determined by the relationship among the various components of a perceptual field, and not by the fixed characteristics of certain components.

In the late 1930's, Lewin (1939/1951, pp. 148-53; 1943/1951, pp. 53-6; 1946/1951), in his field theory, draws this relativistic metaphor into the realm of the animate individual's social behavior. He draws upon two disciplines. From the mathematics of topology Lewin borrows axioms for the graphic definition of structures as the relationship among spaces with open or closed boundaries. From physics he draws principles for the dynamic description of action and interaction by these structures, over time (Cartwright, 1959; Hall and Lindsey, 1970, pp. 197, 225-6).

Bertalanffy (1968), in the 1920's, advocated a conception of organismic biology which sees the living organism as an active whole, whose parts are mutually interdependent and interactive, and whose biological unity is interdependent with the external environment (p. 12). General systems theory challenges old scientific views against purposive behavior and teleology as "mechanistic". In general systems theory, Bertalanffy sees a revolution in scientific thinking. It bypasses the limitations of analytical procedures in which an entity is investigated by resolving it into its parts and reconstituted from the sum of its parts. General systems theory recognizes the interactive relationship among parts, unaccounted for in the earlier view (pp. 17-19). Thus, problems once unmanageable for science may be "progressively explored" (p. 23). His aim is a "better understanding, explanation, prediction, control of what makes an organism, a psyche, or a society function" (1969, p. 36). This aim presents opportunities to expand social work's knowledge and practice bases.

Basic Systems Conceptions.

The part-whole relationship. In a systems conception, the whole is equal to more than the sum of its parts. In a simplified illustration, a square board and four sticks are a square board and four sticks. Put them together in one way and you have a table. Change the relationship of these components, and you have

an empty picture frame. Change their relationship again, and you have the frame of a pyramid. Add hinges to the "legs" to create a folding table to store in a narrow space. Thus, *relationships* among the *parts* of these simple inert systems give to the *whole* potentialities which it would not have if seen merely as the sum of its parts.

Transactions. These relationships are *actively* conceived in *living* systems terms as processes called *transactions*, which maintain or enhance the system. Transactions occur at *interfaces*, the "surfaces" or boundaries which two or more parts have in common. The process of information crossing interfaces constitutes a transaction. We learn about the state of the system, its processes and structures by observing transactions among its parts, and between it and other systems. Transactions serve as primary data. Other information is derived or inferred, based on our understanding of how systems function *in toto* (Stein, 1974, pp. 66-72). In an ecological perspective, transactions are "continuous reciprocal exchanges in the unitary person:environment system, through which each shapes, changes, or otherwise influences the other over time" (Germain & Gitterman, 1987, p. 489).

We have previously reviewed the implicit values of *determinism* and *holism* as they have reappeared in major reformulations of a clinical-normative model for casework. Movement has been away from a rigid determinism, toward more holistic and organismic approaches. General systems theory

certainly fits with this trend. The emphasis on transactions allows for an organismic viewpoint. Its encompassing quality belies its potential for holism.

Equifinality. The principle of *equifinality* may be seen as an "anti-determinist" principle. It means that a living system's "final state" may be attained from varied beginning conditions in diverse ways. One particular history alone is not the only route to a particular state, with all cybernetic systems, whether living or non-living (Miller, 1969, p. 125). Gray and Rizzo (1969, p. 15) note that "equifinality is characteristic of open systems tending toward a steady state. Equifinal phases are reached from different starting points." They are maintained for an interval until progressive forces induce a "new equifinal phase."

A living system is an open system. The relatively open boundaries of the system, and of its component subsystems, allow for communication of "information" which helps to maintain and enhance the internal organization of the system. A relatively closed system, however, will move toward further disorganization, entropy and eventually cease to exist as a system; it will become merely the sum of its parts. Hence, the acceptance of a living systems approach acknowledges the principle of negative entropy as necessary to the enhancement of life processes and their progressive organization. It is a process in which the living system restores its own energy and repairs breakdowns of its organization (Miller, 1969, pp. 72-5).

The concepts of teleology and purposeful behavior. For Bertalanffy, "'purposefulness' in the living world means only that...events are arranged so as to guarantee the maintenance of the organism.... This is not an anthropomorphic interpretation of happenings in the living world, but a simple observation of an apparent and essential characteristic of living things" (1975b, p. 69). Thus, the issue of purposeful behavior is seen as a legitimate scientific question (1975a, p. 43).

These concepts are actively rejected by mechanistic science as "unscientific, metaphysical...remnants of primitive animistic thinking" (Bertalanffy, 1975a, p. 43). In the linear-mechanistic approach, determinism is operationalized through assumed "laws" of nature. A person, group or society has little control over these laws (Bertalanffy, 1968, p. 16). Thus, the person, group or society largely develops without its own purpose, yet purposefully must try to affect its own development.

The conflict between determinism and free will runs deep in modern psychology and social science. Psychoanalysis has dealt with the conflict by calling upon the concept of *overdetermination*, which is a form of linear causality, in which several historical lines of causation sequentially or simultaneously determine an effect (Freud and Breuer, 1895/1955, pp. 173-4, 212-213, 263, 287-90; Munroe, 1955, pp. 54-5).

The living systems approach minimizes this polarity by accepting the notion of purposeful behavior. Self-maintenance, elaboration, and differentiation toward increased organizational

complexity are seen as the purpose of a living system. Entropy and disorganization need not be ultimate ends. We may observe a system's attempts to maintain this steady state, toward which a living system is deemed to strive. It reflects the purpose of the system. This purpose is not, however, so much inferred out of choice as out of necessity. Miller elaborates that those systems which lack purposive movement toward a "focal condition" (which is a future degree of organization equal to or greater than that of the current steady state) will disorganize through entropy. Systems theorists attribute the choice of self-maintenance to purpose rather than to chance, for living systems (Miller, 1969, pp. 121-5).

Etiology is seen in terms of forces and situations (Auerswald, 1969, p. 377). The state of organization, whether steady, increasing or decreasing, is the result of the state of each system component *in active relationship to other components*. Etiology is reflective of the past through the mechanism of feedback over time. Feedback enables a system to continuously assess its steady state, which is never static (without reference to particular "causes" which inevitably, by particular "laws," might lead to a particular steady state). Change from one state toward another state occurs via exchange of information (transactions) which are monitored through feedback. A system continuously assesses feedback in order to move toward, or away from, or maintain a particular state (Miller, 1969, pp. 114-18, also 68-9, 100-08).

Some Historical-Theoretical Notes on Ecological Conceptions.

The word *ecology* derives from the Greek *oikos*: a house or place to live in, a habitation (Shepard, 1969, p. 1). Since its first use by the biologist Haeckel in 1868, notes Hawley (1950, p. 3), it "has become generally recognized as an important branch of the biological sciences."

Darwin's theory of evolution may be seen as laying the base for a conception of common bonds among organisms (Shepard, 1969, 6). Ecology deals with the relationship between organisms and their environment. It is based on a view of "life as a system of dynamic interdependencies." Every organism, man included, is in a continuous process of adjusting to an environment which is external to itself (Hawley, 1950, p. 3). Organism and environment represent one functional unit. In the larger context, ecology refers to the adjustment to, and use of environment by an organized aggregate living population (Hawley, p. 66). With a focus on human groups and their capacity to manipulate their environment, McHarg (1969, p. 328) provides a broad description of ecology as a study of interactions of organisms with environment which contains other organisms. As stated by Rogers (1960, p. vii), human ecology is seen as "the study of the relations between man and his environment," as each affects the other.

Nevertheless, as Shepard states, ecology cannot be studied directly. "Only organisms, earth, air and sea can be studied." Ecology is "a scope or a way of seeing," a perspective (1969, p.

1). This view requires a shift in our frame of reference and attitude toward life, so that relationships among things are as seen as being as real as the things, themselves (p. 3).

An ecological perspective provides knowledge about the delicate relationships between people and their "changing physical and social environments." Ecology concerns "itself with the adaptive fit of organisms and their environments and with the means by which they achieve a dynamic equilibrium and mutuality." She elaborates that ecology provides a metaphor for a helping profession "concerned [a] with the relationships between human beings and their interpersonal and organizational environments, [b] with helping to modify or to enhance the quality of transaction between people and their environments, and [c] with seeking to promote environments that support human well-being" (Germain, 1973a, p. 326).

The ecological metaphor provides an environmental context in which to apply the life model in a systems framework. We conceive interventions in natural life processes in a person's life space. In contrast, casework in a medical-disease metaphor requires contrived processes in a created setting. At the service level for Germain, casework in the ecological metaphor encompasses the entire person in a "fluid real-life situation." It utilizes the healing and growth potentials of "human adaptive and coping capacities," and real social supports (Germain, 1973b, pp. 130-1).

Basic Ecosystems Conceptions.

Ecosystem. The term *ecosystem* was coined in 1935 by Tansley, a British plant ecologist. It specifies a holistic unit, composed of vegetation and its environment, which includes climate, soils and animals. It refers to an entire site or habitat and everything included in it. There have been two trends in the use of the term ecosystem in contemporary literature. One focuses on productivity and energy relationships within the ecosystem. The other deals with the methodological problems of actually describing the ecosystem *in toto*. It is in the second area that notions of the "human ecosystem" in psychology and sociology are central (Egler, 1968, p. 247).

"Systems theory and its various derivatives," says Willems (1977, p. 54) "offer promising tools for representing *interdependence* and simultaneous, time-related complexity." An ecological-systems approach may be seen as an attempt to apply the life-principles of the open system to the human ecological field. We choose the components of this field by ascertaining the processes within it which are necessary to the maintenance of life. These processes are transactions, operationalized as "communications processes" at interfaces between components the system. These "communications processes" include notions of transformation and exchange of matter and energy from a more concrete viewpoint, and the exchange of information from a more abstracted viewpoint (Stein, 1974, 18-24, 37-8; Miller, 1969, pp. 68-83).

Adaptation and fit. Hawley in his work on human ecology sees "the central problem of life" to be *adaptation* "to those external conditions which provide the materials for existence, but which also impede and limit expansion" (1950, p. 16). Adaptation is a reciprocal concept which we may see expressed through the concept of fitness.

Fitness, says Dubos (1972) "denotes fine adjustments among the various components of a system" (p. 180). Fitness of the organism to the environment is conditioned by progressive, evolving adaptation over time. Fitness of the environment to man involves man's design of his environment not only to avoid disease and pain, but to "aim at creating conditions favorable for the development of man's anatomical physiological potentialities" (p. 190). "Man...does not react passively to physical and social stimuli.... He selects a particular niche, modifies it, develops it to avoid what he does not want to perceive, and emphasizes that which he wishes to experience" (Dubos, 1968, p. 49).

Goodness-of-fit is an expression of the mutual, ongoing, suitedness and fit of the environment to human needs, both in smaller molar settings, as well as in the larger community. As stated by Alexander (1970), "an irregular world tries to compensate for its own irregularities by fitting itself to them, and thereby takes on form" (p. 42). In applying this notion to design for human needs, he speaks of a "good fit" as opposed to a "misfit" as "a condition of harmony...in the ensemble" (p. 48).

Dubos (1965, pp. 256-79) implies a relatedness, even an equivalence, between health and "adaptive fitness," which constitutes not only a reciprocal adaptation between species (or person) and environment, but a range of capacities and limitations for such adaptation in past inheritance, current life, and anticipated future behaviors.

In the ecological perspective, humans and the human environment reciprocally shape one another in ongoing adaptive processes. Social structure and institutions, and cultural expectations and norms in a historical era, "must support reciprocity, that is, they must be nutritive" (Gitterman & Germain, 1976a, p. 2).

Stress and coping. *Stress* is a transactional concept which refers to a substantial state of "imbalance between the perceived environmental demands and people's perceptions of their response capabilities" *Coping* is a transactional concept with a twofold requirement. It requires not only that the individual possess capacities and skills to deal with environmental demands, but that society provide the learning opportunities, motivational incentives and supports for the individual to develop and sustain the inner biological, psychological, affective, cognitive and perceptual processes which are needed for effective coping (Gitterman & Germain, 1976a p. 3). Simply put, when coping goes well, a state of adaptedness, of fit, may be said to exist between person and environment.

The Life Model: Antecedents.

If we combine living systems principles and the metaphor of human ecology, we have what may be called an ecological-systems approach to understanding people. A model for practice which fits with that approach is the *life model*. It may be traced to Bandler's work (1963, p. 33) in ego psychology. He enunciates a foundation on which to build principles of ego-supportive casework, by starting with the assumption of "progressive forces" and "regressive forces" in opposition. "Other things being equal, progressive forces are the stronger." Mental illness is seen as "an expression of blocks, obstructions, interferences, arrests and fixations of the progressive forces, which leads to...strengthening and reinforcement of regressive trends. Our therapeutic task...is twofold." One task is to identify and provide help in removing these obstacles. An orientation toward pathology makes this task central for many psychotherapists. A second task, which tends to be "neglected," is to identify progressive forces with which we can ally and mobilize at an appropriate time.

Oxley (1971, p. 628) further develops the life model by linking it to five forces of natural change which are not mutually exclusive. These are (a) maturation, (b) interaction, (c) action, (d) learning, and (e) crisis resolution.

Chin (1969) distinguishes between a model for "change" and a model for "changing". The former explains *how* a system undergoes change (i.e., its processes). For the latter, the change-agent uses what he knows of technical processes to help

the client system make *choices* about the scope and direction of change, and then facilitates change in the client system (pp. 308-11). Chin proposes the use of systems concepts, including concepts of development over time, to formulate an intersystem model for changing. While the model is implicitly presented in a community organization context, the author envisions its applicability to "diagnosing" different sized "units of human interactions--the person, the group, the organization, and the community" (p. 298).

If we conceptualize change through intervention as occurring within a system, we must then determine the perspective which provides the largest number of effective "points of entry" into the system to facilitate change. Bandler (1963, p. 31) proposes *life itself*, "the natural process of growth and development and the rich trajectory of the life span." Oxley links "change" to "life's natural processes of maturation and growth" (1971, p. 628) which occur for an individual. Thus, the life model may be said to provide a framework for the description of change in both developmental *and* current terms.

Oxley's (1971, p. 633) suggestion that interventions be chosen with an eye toward facilitating the "natural change processes" is supported by Germain (1973a, p. 326) who notes that practice in a life model may provide needed action concepts to guide the practitioner in engaging a person's progressive forces and adaptive potentialities, and in "mobilizing the environmental processes as helping media," and changing the environment.

The Life Model: Initial Formulation.

The conception which made the life model unique as it emerged in the latter half of the 1970's was (a) the joining of emphasis on both persons and environments with (b) an effort to integrate method specialization (Gitterman & Germain, 1976b, p. 601). In their presentation on the integrated approach of an "ecological-reciprocal perspective" to the Council on Social Work Education, Germain and Gitterman (1975), espouse a focus on reciprocity in the person-environment problem conception, and mutuality in the helping process.

In "Social Work Practice: A Life Model," Gitterman and Germain (1976b, p. 602) present a conceptual base for the life model. It is "through an ecological perspective and a reciprocal conception of social work function [that] people and their environments receive simultaneous professional attention." The notion of "problems in living" encompasses issues implicit in "personality states" and "environmental states." People are seen as "evolving and adapting through transactions with all elements of their environments." As per Hartmann's conceptions of alloplastic and autoplasic adaptation, people are seen as forming the environments in which they live, and then having to adapt to their creations.

The authors (Germain & Gitterman, 1975, pp. 2-4; Gitterman & Germain, 1976a, 1976b, pp. 602-3) implicitly call upon the work of Gordon (1969) and Bartlett (1970) with reference to the functions

and tasks which emerge from the profession's purpose of improving people's coping capacities and environments by a transactional emphasis on the person-situation interface. A three-phase helping process applies to all modalities. In the three cited articles (1975; 1976a, 1976b), the authors specify three areas of problems in living which are faced by individuals, families and groups. These are (a) transitions in life, (b) environmental obstacles and (c) dysfunctional interpersonal processes. Through contracting, problems and/or needs are identified and partialized in a joint worker-client endeavor, to be mutually melliorated over time and eventually evaluated. It leads to a mutually defined, partialized division of labor: The client's focus is life tasks; the worker follows shifting client concerns, utilizes knowledge and skill in communication and in action which restructures situations, and draws upon environmental processes and resources.

Transitional problems and needs include periods in individual development when age-specific, *maturational* processes "transact with phase-specific environmental nutrients." *Status-role changes* occur during one's lifespan which may or may not coincide with biologically determined developmental stages, from parenthood to retirement, to migration, job change, or the stigmatized status of being a psychiatric patient. Transitions also include expectable and exceptional *crises*, such as losses which are unexpected, premature or catastrophic, and whose immediacy and enormity set them apart from role transitions. Shifts,

replacements and mobilizations of adaptive patterns, coping capacities, sense of identity, and environmental resources are all called into play. It is important that there be opportunity for resolution of life tasks in life situations which fit with a client's sense of time and space, life style and aspirations (Gitterman & Germain, 1976b, pp. 603-5).

The realm of help with *environmental problems and needs* concerns itself with adaptive issues arising from both social and physical environments. Social networks, institutions and organizations comprise man's created *social* environment to which he must adapt. *Physical* environments contain natural and man-made things, and time and space (Gitterman and Germain, 1976b, p. 605). Included in the *social environment* are service organizations, some of which may be tuned into client need, while others may be more geared to institutional homeostasis. Being a client, in some instances, may be stigmatizing (p. 605-6). *Social networks* of family, friends, neighbors and peers meet needs for relatedness, recognition, protection and cultural identification. They may also reinforce deviance and undermine autonomy. Some people lack adequate (or any) social networks. It is through the drawing on adaptive attachment behavior and/or the development of new relational experiences that a client may be helped to create and relate to an environment which enhances life processes. Arrangements of physical space (whether in home, classroom or hospital ward) "may invite or discourage particular behaviors,"

and must be considered in evaluating maladaptive coping patterns. Interventions directed toward spacial variables or toward a client's experiences in the natural world, "enhance relatedness and increase the nutritiveness of the environment" (pp. 606-7).

Maladaptive interpersonal problems and needs in families and groups include relationship and communication patterns which "may be poorly understood or altogether outside the members' awareness." Patterns such as power struggles, scapegoating and double bind may serve latent functions of maintaining system equilibrium, with maladaptive consequences for some members. Assessment may reveal sources of interpersonal conflict such as (a) discrepancy between life transition tasks of the collective and the individual; (b) "dysfunctional accommodation to environmental pressures and inadequacies;" (c) discrepant orientations of members to "power and love;" (d) "normative conflicts among members;" and (e) problems related to the group's composition. Interpersonal barriers may also show up between client and worker. These are seen not as resistance, but as transactional, maladaptive relationship processes and communication distortions which arise from affective, cognitive, perceptual, transference and countertransference incongruities and discrepancies in client-worker transactions. The worker must remain continuously vigilant concerning possible barriers, and bring them into open discussion for mutual attention (Gitterman & Germain, 1976b, p. 609).

Parallel Development of Related Formulations: Interactions of People and Environments in a Unified Practice Framework.

In Social Work Practice: Model and Method, Pincus and Minahan (1973) present a practice framework, whose "common core of concepts, skills, tasks and activities which are essential" to practice, reflect a professional unity and cohesiveness (p. xi).

They see social work's function as concern with "interactions between people and their social environment which affect the ability of people to accomplish their life tasks, alleviate distress, and realize their aspirations and values," by (a) enhancement of people's problem-solving and coping capacities, (b) linkage of people with systems which provide them with resources, services and opportunities, (c) promotion of humane effectiveness of these systems and (d) contribution to social policy (Pincus & Minahan, 1973, p. 9).

Their intent is (a) to work directly with connections between dichotomous elements of "person/environment, clinical practice/social action, and microsystems/macrosystems." (b) Work may take place with people who are not identified clients but who affect planned change efforts. (c) Method(s) of practice and size of the system(s) addressed are based on the "task at hand." (d) The frame of reference derives from the profession's function and purpose, and is not tied to a substantive theory. (e) The model is deemed useful in a variety of situations and settings. (f) It is guided by a goal-oriented, deliberate, planned-change view of

practice, based on tasks in which the worker engages "in action as he works to change elements in a social situation in order to achieve a specified goal or outcome." The model is conceived as a base for practice in any method, in a generalist or specialist orientation (Pincus & Minahan, 1973, pp. xii-xiii).

The authors (1973, pp. 9-14) observe three characteristics of a social work frame of reference. These are (a) the performance of life tasks in a context of "resources and conditions" and which allow people the capacity to cope; (b) interaction with resource systems such that people's problems are seen as a function of their social situation; and (c) the relationship between people's private troubles in a social situation and policy issues which bear on these troubles. They cite C. Wright Mills (1959, p. 8) to distinguish between resolution of personal troubles as immediate and personal matters, and as public issues which transcend both inner life and local environment. They note Schwartz's formulation (1969, p. 38) of the linkage between family or individual problem solutions and the public issue domain in the arena of the social agency, namely that "a private trouble is simply a specific example of a public issue, and...a public issue is made up of many private troubles."

In a community organization orientation, the authors declare that activities of the social worker "can be viewed in relation to four types of systems" (Pincus & Minahan, 1973, p. 54). (a) The *change agent system* (worker and agency) carries the change

responsibility, and is influenced by its own inner and outer constraints and conditions and by the client system. (b) The *client system*, which may include potential as well as actual clients, engages the social worker's services as a change agent with some sort of working agreement or contract as to problem and intent. (c) The *target system* comprises the people whom the change agent needs to influence, directly or indirectly, in the accomplishment of his goals. Client systems and target systems often overlap, as when different members of a family seek (client system), or need (target system) help. (d) The *action system* includes the change agent and people through whom he works to achieve goals and influence the target system (pp. 53-68).

Outcome goals are the envisioned state of a planned change effort. They are conceived, not merely in relation to the client in isolation, but "in relation to the outcome goals of all systems involved in a planned change effort" (Pincus & Minahan, 1973, p. 87). Design and implementation of tasks to achieve of outcome goals is "the heart of practice." In order to link purpose and task, the worker must draw on practice skill and social science knowledge. The authors identify eight vital practice skills for the translation of purpose into task. These comprise the processes of (a) problem assessment, (b) data collection, (c) initial contacts, (d) contract negotiation, (e) action system formation, (f) action system maintenance and coordination, (g) influence use, and finally (h) termination (pp. 96-8).

Of interest in this four-system view of social worker activities is the influence of community organization as developed in the 1950's and 1960's with social science theory drawn from the group dynamics movement whose roots go back to Kurt Lewin and field theory. While the group dynamics movement was not well received by early group work leaders, for its use of experimental methods with human emotions in the 1940's (G. Wilson, 1976, p. 28; Hartford, 1971, p. 14), its concepts *later* made their way from the social sciences (Hartford, 1976, p. 50) and from community organization into efforts to broaden practice (e.g., Lippitt, Watson and Westley, 1958).

Parallel Developments of Related Conceptions: Focus on Environments in the Structural Approach.

Middleman and Goldberg introduce their book Social Service Delivery: A Structural Approach to Social Work Practice (1974), by stating that vital measures of service, in addition to quality, are its nature, goal, distribution and delivery; and its accessibility to the poor and powerless (pp. 4-5). The authors define the "microlevel" of practice with a unit of attention labeled "plight of individuals." The "macrolevel" view of people in society comprises a "perspective of general problems such as poverty and delinquency." The structural approach is a "microlevel practice model, consistent with [a]...social welfare-through-social-change philosophy [sic]" (pp. 5-6).

The structural approach stresses environmental adjustment to meet the needs of individuals, as contrasted against other practice orientations which seek to help individuals adjust to situations, gain insight, or change ways of thinking and acting (9). The two assumptions of the model are (a) that individuals' problems are a manifestation of social disorganization, and (b) that "social change is the obligation of the social worker, and *begins* with the direct service conceptualization of a response to a suffering individual (Middleman & Goldberg, 1974, pp. 12-13).

Two dimensions, which the authors (1974, pp. 18-23, 24) visually depict as two axes on a graph, known as "locus of concern" and "persons engaged" are utilized to describe four conceptual categories of activity, visually pictured as four graph quadrants, with which social work is concerned. These categories include activity which involves the worker's *direct contact with a particular sufferer* (a) out of concern for that sufferer, and (b) out of concern for a related category of sufferers; and *direct contact with others* (c) out of concern for a category of sufferers, and (d) out of concern for a particular sufferer. The first two categories involve direct engagement of one or more people to benefit them, or to benefit of others like them. The third includes research, policy development and social planning; while the fourth includes community-oriented practice. This model for research and policy planning, is seen as enabling focus both on the service, and on gaps in its delivery to underserved groups.

Middleman and Goldberg (1974, pp. 28-31) see this four quadrant model as allowing for a conceptualization of specialization which is related to the actual work, rather than a conceptualization which evolves for historical reasons and is later justified with partial theories. Practitioners whose work covers all quadrants *but* that of direct contact with "others" out of concern for a "category of sufferers," is seen as being involved in the service delivery realm. Those social workers who work in all quadrants *except* direct service to a "particular sufferer" out of concern for that sufferer are seen as specializing in social policy and planning.

The approach's four principles follow: (a) *Accountability to the client(s)* includes a contract to operationalize accountability. (b) *Following the demands of the client task(s)* requires the worker to flexibly move from one type of service quadrant to another (such as from direct service to a sufferer, to service to others on behalf of the sufferer. (c) *Maximizing the potential supports in the client's environment* involves modifying existing structures and the creation of new ones, to meet people's needs. Finally, (d) an assumption of *least contest* requires the worker to exert the least amount of pressure needed to accomplish a client task, with minimized counterpressure and resistance in the target systems (Middleman & Goldberg, pp. 32-53).

Roles of advocate, mediator, broker and conferee are seen as enabling for the client in task accomplishment (Middleman & Goldberg, 1974, pp. 54-80). The role of *advocate* is a difficult

one, in providing help to a powerless client. The worker must attend to the ongoing importance of both informed client choice and pitfalls of conflict escalation between client and target system. He must adhere to the principle of least contest and enter a system at the lowest possible hierarchical level, proceed upward, and be ready to shift stance when concession is obtained (pp. 55-9). The role of *mediator*, formulated in social work by William Schwartz, is based on the concept of mutual aid. Mediation, in this practice model, presumes a not-yet operational but nonetheless existing, complementary or identical common bond between parties, which a mediator must help the parties to rediscover (pp. 59-65). The role of *broker*, linking clients to community resources, assumes the existence of clear, complementary interests of client need and agency service. The authors (pp. 65-72) describe brokerage as the oldest social work role, originating with friendly visitors and settlement house workers. It entails location, interpretation and creation of resources for those in need. The role of *conferee*, involves a "conference" encounter in which the worker and other(s), equally obligated participants, who jointly consult, compare opinions and deliberate, and develop action to be implemented. It is a decision-making process which in some helping relationships, may be the worker's principle role. In some situations, movement into conferee roles for worker and client may highlight initial exploration and task accomplishment, at the beginning and ending phases of the work.

In their effort to move toward greater precision in practice, Middleman and Goldberg (1974, pp. 83-7) emphasize *skill*. They define "skill" as the production of specific behaviors which are directed toward specific outcomes. There are twenty-seven specific behaviors which are tied to conditions which facilitate their use. These behaviors are conceptually grouped into six skill areas: (a) *Stage setting* calls for behaviors which needed to initiate interaction. (b) *Attending* involves taking in data. (c) *Engaging feelings*, and (d) *engaging information* refer to behaviors which deal with and take in both the affective and informational content of messages. (e) *Managing interaction* involves behaviors which monitor message flow. (f) *Engaging barriers* refers to use of behaviors which reduce or remove barriers to task accomplishment.

Ongoing evaluation is referred to as *analytic behavior*. It involves (a) utilizing a frame of reference (a theory) through which to impart meaning to data and (b) cognitively exploring alternative explanations, from the points of view of both patterns over time, as well as moment-to-moment phenomena. Other components of analytic behavior are the understanding of (c) social contexts, (d) of overt and covert motifs and (e) of underlying metamessages which contradict expressed themes (Middleman & Goldberg, 1974, pp. 87-9).

Work which is not directly part of direct engagement with client tasks in service delivery is given the term "metawork." Professional development and agency-related tasks fall into this

category. These may or may not be supportive of service delivery (Middleman & Goldberg, 1974, pp. 153-5). "The plight of workers in bureaucratized systems who cannot find time to serve the enormous number of clients at least partially springs from the disproportionate amount of metawork to work, ritualized by the agency through history and tradition" (p. 155). In this context, attention to the metawork and to the structure of and forces within the agency itself as an organization is vital as the metawork impacts on agency effectiveness, staff morale and productivity, program, and ultimately on service delivery (pp.170-8).

For Middleman and Goldberg (1974, pp. 183-9), choice of social science theory has political implications, based on what is and is not emphasized. Theories are tools to be used in the performance of professional assignments. Social theories which locate the problem in the environment are seen as being compatible with values which underlie the structural approach. By virtue of its view of the problem source as lying within the individual, psychoanalytic theory is seen as incompatible with the structural approach.

Parallel Development of Related Formulations: Action and Competence.

Maluccio and Marlow (1974) note the literature's lack of a comprehensive formulation about "contract." They clarify its purposes as a shared opportunity for explicitness in a process of

articulating differential expectations, roles and responsibilities. It enhances client self-determination, is open to reformulation, is flexible, and signifies joint contributions to a positive outcome.

Maluccio (1974, p. 30) discusses *action* as a practice tool in casework. He sees no theoretical approach which provides sufficient rationale for the use of action in practice, nor for the development of practice-related principles about its use. Maluccio (p. 31) examines uses of action in casework. He draws on the ego psychology formulations of Hartmann, Erikson and White who view the person as an active, and not simply reactive, life participant. Examples of action include (a) role playing in family therapy, to enhance client capacity to cope, through concrete experience; and (b) encouraging parent-child participation in social activities in residential treatment to promote competence and a positive sense of self. This is seen as congruent with principles of ego psychology, which highlight the value of action for autonomy, competence, self-image, potentiality, creativity and mastery. It also makes alive the tenets of client participation and self-determination. It enables the worker to "identify, mobilize, and ally himself with the client's potentialities, natural life processes, and adaptive patterns." It coincides with "a revitalized casework method patterned after life itself," and with the use of purposive activity to stimulate "growth, adaptation and progressive forces."

Maluccio (1974) conceptualizes the use of action as a diagnostic tool, an instrument of treatment, a culmination of

treatment, an outcome measure, and a means of mobilizing people and resources "in the client's ecological context" (p. 31). He distinguishes between use of *artificial activities* provided for a client's benefit (such as role-playing and activity groups) and *action which occurs naturally* in a client's life (such as social interaction, work, and play). Maluccio sees the latter as more meaningful and potentially more effective, as it is closer to the individual's life process of growth and adaptation (pp. 31-2). As a central rationale, he cites White's formulation of *effectance*, emphasis on the ego strengthening effect of *successful interaction with the environment, feeling of efficacy*, and "cumulative development of a sense of competence." Thus, "engagement in purposive, goal-directed activities can stimulate the person's coping efforts and strengthen his adaptive capacities" (p. 32). It counters helplessness, low self-esteem and poor reality-testing which may be experienced in the helping process (p. 33).

For action to be effective, a client must be ready, motivated, and experience tension such as anxiety or a hopeless dream (Maluccio, 1974, p. 33). Mutual effort is vital to help a client evaluate alternatives and reach agreement on meaningful goals, tasks and procedures to be achieved by and with the client with support systems and not in isolation. The systems theory concept of *equifinality* may enable the worker to recognize the possibility of varied pathways to the same result. Emphasis is on the growth potential of life events through action (pp. 34-5).

CHAPTER III

Theoretical and Historical Considerations

Since the Late 1970's

Some Developments in the Ecosystems Perspective

On Ecological Inquiry.

Bronfenbrenner in The Ecology of Human Development (1979, pp. 18-21) takes an interesting position on inquiry and research. He refers to McCall (1977, p. 336) who sees naturalistic inquiry as limited in its ability to provide necessary and sufficient conditions for the manipulation and control of relevant variables, toward the unequivocal demonstration of causes for many major behaviors. Bronfenbrenner (p. 20) rejects McCall's "implied dichotomy between rigor and relevance and the assumed incompatibility between the requirements of research in natural situations and the applicability of structured experiments at an early stage in the scientific process." He sees the experiment as a powerful, basic heuristic tool. For Bronfenbrenner, an experimentalist view of research on human development (a) has ethical and practical limitations for manipulation of variables, (b) dictates rather than serves the ends of inquiry, and (c) excludes the breadth of naturalist observation. Yet a naturalist position need not exclude a place for a rigorous experimental approach.

Two themes about ends and means of ecologically-oriented human development research stand out for Bronfenbrenner (1979).

First (as in the naturalist paradigm), the main purpose of the ecological experiment is not hypothesis-testing, but *discovery* of "systems properties and processes that affect and are affected by the behavior and development of the human being" (pp. 37-8). He describes the Soviet *transforming experiment* by citing a verbal communication with Professor A.N. Leontiev that American researchers seem to seek to explain how a client has become what he is, while those in the Soviet Union strive to discover how he may become what he is not. This involves an informed "systematic alteration and restructuring of existing ecological systems" to challenge prevailing social organization, belief systems, and an analysis of results in systems terms, with an eye to discovery of new social forms as contexts for realizing human potential (pp. 40-1). Second, "the understanding of *human* development demands more than direct observation of behavior; "it requires examination of multi-person systems of interaction not limited to a single setting and must take into account aspects of the environment beyond the immediate situation containing the subject" (p. 21). Inquiry need not be limited to the environment with which the subject is in direct contact; it may also be remote and still have a direct effect on the human phenomenon under study. This refers to the reciprocity and interdependency of proximal as well as not-immediately-present persons, environments, settings and processes in systems terms (pp. 41, 68). For research findings, Bronfenbrenner conceives *interactions* as the centerpiece of main effects in ecological research (p. 38).

On Knowledge Building in Social Work.

Gordon (1983, pp. 182-3) extrapolates on his agreement with E. J. Thomas's position (1980, p. 91) about knowledge building in the human services, to indicate that there is a valid difference between research which emphasizes technological innovation for human services and methodology geared toward behavioral science knowledge building. Gordon sees the advancement of social work not as contingent upon particular research technique or methodology, but rather as resting upon the structure of social work knowledge, itself. Thus, eclecticism (useful in both practice and research) may result in the use of different approaches in method development. Such eclecticism, however, is useful only within the context of the broader paradigm. Eclecticism, for Gordon, cannot exist in an informed and usable fashion without a blueprint from which to serve as a basis for deciding on the nature of the problem is.

Gordon (1983) sees the ecosystems approach as possibly providing "a conceptual framework for understanding the context of social work practice and the problems with which social workers deal" (p. 182). He highlights a "slow but documentable evolution... [in] a growing recognition that social work has a frame of reference (maybe a crude paradigm) different from that of other disciplines: consideration of both person and environment in any effort to resolve a problem (p. 183).

Gordon (1983, p. 184) sees a deficit in the general use of "human behavior" as the implicitly sought change in social work

practice, and as the generally utilized dependent variable in research. He believes that such research language--and by extension practice thinking--has tended to sidetrack the profession's ability to bring together conceptually the person and the environment as the two sources of independent (so called "causal") variables; and has sidetracked the profession's working toward a restatement of the dependent variable in a manner which accounts for a dual professional focus.

Gordon (1983, p. 184) states that (a) "shifting the critical dependent variable from behavior over to the growth and development of individuals involved in attaining their human potential on the one hand and improving their environment on the other extends the dual focus from cause alone to outcome."

(b) Establishing as the "new independent variable the *match* between the coping behavior of the individual and the qualities of the impinging environment," underscores that both environment *and* coping patterns are modified by man in order to effect a match which brings about change. In a summary look to the future, Gordon sees the profession's major task as firming up its basic frame of reference in pursuit of "a conceptual elaboration of the interface between the person and the environment and the ways of assessing and changing both the person's coping patterns and the impinging environment when this interface does not result in a match that is conducive to the development of man and all aspects of the environment."

On the Perspective: An Overview.

Meyer (1983a), pointing out the need for "a linkage between method and purpose" (p. 8), speaks of the ecological systems perspective as an integrating "conceptual umbrella beneath which all practitioners can practice with an eclectic repertoire to carry out a common purpose" (p. 5). She sees consensus about *models* for practice rendered impossible by the large number of contemporary proliferating practice *models*, which in her view necessitates a common *perspective* for practice (p. 8).

Meyer sees a need for an approach which considers *context* as a more inclusive transactional perspective under which various models may find a place to be called upon by a clinician. This requires a shift in the profession's central concern from an orientation which is focused on methods and skills to one in which a knowledge base is at the foundation. A knowledge base serves as the lens through which to view phenomena with which they work, determine needed interventions, and choose indicated methods through which to meet case requirements (1983a, p. 26). She views earlier, longstanding emphases on method as having resulted in models which highlight the process of practice (1983b, p. 243) (and in some models, such as the psychosocial model, client-related *content* as well). With the exception of the life model (as well as crisis intervention, and Siporin's "Situational Assessment and Intervention"), no model addresses "substantive psychosocial problems." The life model has begun to do so with its "general

definitions of problems, such as transactional life events, environmental obstacles, and interpersonal obstacles" (1983b, p. 243).

Meyer (1983a) sees the life model as built around a unified process that enables it to meet practice requirements with individuals, families and groups. It supplants the professions linear approaches (p. 28). As a practice model, "it attempts to apply the [ecological] metaphor directly, through interventions and goals, as an instrument of direct social work practice" (p. 29). Eco-systems theory is described as "a metatheory that offers social work practitioners/clinicians a way of thinking about and assessing the relatedness of people and their impinging environments; it does not specify the *what* (problem definition) or the *how* (methodology) of practice" (p. 29).

For Meyer (1987), Gordon's and Bartlett's work on formulating a foundation for social work practice with emphasis on its common base, permitted the social worker "to be released from an *a priori* commitment to methodology," which would set the stage for the possibility of a more holistic view of case-related issues and intervention possibilities (p. 413). She elaborates that "the purpose of a perspective on practice is to bind together social workers who are all doing different things to carry out the same purposes" (p. 414).

Basic Premises of the Life Model

In The Life Model of Social Work Practice, Germain and Gitterman note (1980, pp. ix-x, 2-7) their collaborative effort to develop an integrated practice method with individuals, families, groups, organizations, and aspects of communities. Their assumption is that there are many common skills in working with people, regardless of their level of organization. They contrast pre-twentieth century, subject-object, fragmenting efforts toward certainty against the Eastern view which they liken to [post-positivist] holistic efforts to understand the world. The shift has been represented by movement from a view-obstructing, within-the-person problem of the medical-disease metaphor, to the ecological metaphor which focuses on an adaptive, evolutionary interchange and goodness-of-fit between people and their environments.

Basic concepts in earlier articles (Germain & Gitterman, 1975; Gitterman & Germain, 1976a, 1976b) are operationally elaborated with numerous examples from practice. *Stress*, "a psychosocial condition generated by discrepancies between needs and capacities, on the one hand, and environmental qualities on the other," comes from three "interrelated areas of living: *Life transitions*, *environmental processes*, and *interpersonal processes*." "Life transitions impose new demands and require new responses." The environment may support or interfere with transitions, or "be a source of stress," to the individual, and to primary groups and their interpersonal processes (Germain & Gitterman, 1980, pp. 7-8).

The profession's social purpose, suggested by Gordon (1969) and Bartlett (1970), is the source from which the life model flows. It is the matching of people and properties of the environment "to produce transactions that will maximize growth and development, and improve environments" (Germain & Gitterman, 1980, p. 1). It is from this purpose that function, tasks and roles derive. It is through (a) problem definition, (b) client and worker roles, (c) phase of the helping process, (d) assessment and (e) professional action, by the worker who functions in the midst of the person-group-environment encounter, that people and their environments are helped to "overcome obstacles that inhibit growth, development and adaptive functioning" (pp. 1, 10).

A *problem* occurs at the person-environment interface. *Client and worker*, in transactional relationship, bring to the encounter the influence of interacting forces in their respective life space. Transactional difficulties which create barriers to the helping process are seen not as resistances but as expressions of discrepant perceptions and expectations in relation to status and role, agency structure and function, and professional perspective (Germain & Gitterman, 1980, pp. 10-16).

It is through the *assessment* process that client and worker mutually seek to understand both objective facts and subjective reality. The empathic worker formulates hypotheses which may be modified in light of client feedback, outcomes of actions by worker and client, and worker-client interaction. The worker's stance involves integration of scientific rigor and humanistic compassion.

Assessment, a "habit of mind," is present in all phases, and is occasionally formalized at points in the helping process (Germain & Gitterman, 1980, pp. 18-19).

Action involves a worker's range of skills and techniques, "to increase self-esteem, problem-solving and coping skills, to facilitate primary group functioning, and to engage and influence organizational structures, social networks and physical settings." These are "directed to adaptive capacities and environmental properties, and their interaction," in the context of client action, self-regulation, and achievement of competence. A mutual process occurs to determine a client's motivation and readiness for action in the context of available and responsive support systems (Germain & Gitterman, 1980, pp. 20-1).

The three phases of the helping process, described in operational examples--initial, ongoing and ending--"ebb and flow in response to the interplay of personal and environmental forces ...[and] are not always distinct in actual practice" (Germain & Gitterman, 1980, p. 17).

The *initial phase* requires the worker's informed, cognitive and affective preparation to enter the client's objective reality and subjective life-space. Preparation may include the worker's use of role playing, attention to her own identification with the client's situation and to the reverberation of her feelings and reactions. In her welcoming, eliciting and taking in the client's presentation, she works toward the development of a mutual

understanding of next steps. She attends to situations of *sought, preferred and imposed* services, with differential expectations and explanations to clients in their mutual exploration and definition of the problems, tasks and goals. This process constitutes *contracting* and requires close attention to issues of *client choice*. Contracting engages the client, equalizes power discrepancies, addresses reciprocal accountability and gives focus and structure to the client-worker endeavor. The worker's *skills* must encompass both inquiry and caring (Germain & Gitterman, 1980, pp. 17, 35-75).

Three concepts deal with the worker's dilemma of how broad and deep to explore when the client's stresses call for resolution. (a) *Relevance* refers to how related an area is to the predicament at hand. (b) *Saliency* refers to the dominant features of a client's situation. (c) *Individualization* is the effort to promote focus on the whole, unique person in his social context (Germain & Gitterman, 1980, p. 52).

Choice of *modality* is considered by the process of the worker's looking at the nature of the problem, the relationships and the common concerns and needs of the people involved (Germain & Gitterman, 1980, 57-8). *Time* and *locale*, including rapidity of response, duration and location of service and of specific contacts must be addressed--always with thought to the cultural orientation, and physical and age-related needs of the clients (pp. 59-61).

The *ongoing phase* involves the worker's helping the client deal with coping tasks related to three sources of stress: life transitions, environmental issues and interpersonal processes. This entails a flexible use of modalities, organizations, social networks, physical settings and temporal service arrangements (Germain & Gitterman, 1980, pp. 17-18).

Life transitions include the effects of universal biological growth and developmental changes in the context of a multitude of cultural meanings and social forces. The worker must be in synchrony with clients' biologically triggered individual (and family) *life cycle* and reciprocal cogwheeling of generational needs and tasks. When all goes well, there is a release of *innate* adaptive capacities (such as cognitive development) and the growth of *acquired* adaptive capacities (including human relatedness and self-regulation) (Germain & Gitterman, 1980, pp. 77-89). Cognitive development or regression in the stress of life transitions may result from status and role changes. A new status may be devalued, or out of synchrony with a person's life cycle, or too complex for a person's coping capacities (pp. 89-96). *Crises* are distinguished by their enormity, immediacy and time-limited nature. They are fraught with hazards of regressed functioning, as well as potential for growth (pp. 96-9). *Worker roles* in life transitions may be that of the *enabler* who promotes development and sustenance of adaptive capacities, as well as the direct, instrumental *teacher* and the mobilizing *enabler* (pp. 99-102).

Environmental problems and needs are both social and physical. The social environment includes *organizations* (such as helping agencies). Their internal and external boundaries may be too open, with for example, insufficient effort to serve a client adequately before deciding on discharge; or too firm, so as to duplicate services rather than make appropriate referrals. Authority functions, policies, informal structures and latent functions of an agency may have a negative bearing on service if they are not understood and borne in mind by the worker. A client's *social network* of linkages among significant others may be a source of support and help. Its lack is stress-producing. Life cycle events and transitions as well as geographic and social mobility are part of the environment, and bear on the creation or dissipation of stress (Germain & Gitterman, 1980, pp. 137-47). For heuristic purposes, within the *physical environment*, the authors distinguish the *built* from the *natural world* as shaping one another, and affecting and being affected by social environment and culture, from one's neighborhood to one's self-concept (pp. 147-51). Processes of *problem definition*, *exploration* and *contracting* are continuous in the context of varied worker roles of (a) the collaborative *mediator* who helps the client and social system each to reach out to the other; (b) the influential, pressuring *advocate*; (c) and the creating, motivating, and resource providing organizer (pp. 151-5).

Maladaptive interpersonal process are sources of stress in families and formed groups which, as collectives, share similar interpersonal process. Legal and kinship ties of family membership are contrasted against the time-limited joining of members in a formed group to work on common tasks under agency aegis (Germain & Gitterman, 1980, p. 203).

Procreation and socialization of children are described as universal *family* functions in (a) traditional multigenerational extended families, (b) reconstituted (or step)families, (c) communal families; as well as in (d) post-industrial nuclear families, and their variant one-parent families whose adult members may have been divorced, separated, widowed or never-married. Each type of family has its own particular areas of vulnerability to stress. The authors note that a common characteristic of female-headed, single-parent families is poverty plus a "severe shortage of hands" (Germain & Gitterman, 1980, p. 206) to do needed work. Maladaptive patterns of communication and relationship must be understood in the structural and cultural contexts of a family system. Attention is vital to spousal, parent-child and sibling subsystems, as well as to subsystems of extended family and non-related household members as well (pp. 203-12).

The *formed group* is generated under agency aegis to work on life tasks, as a bounded system. Its two main functions are to provide an ongoing nutritive group-environment interchange, and to establish and maintain a system of mutual aid among its

members, toward the release of individual growth potential. When these functions are effected successfully an adaptive balance is achieved. When internal or external stress upsets that balance, the group copes to regain it, but may do so with maladaptive patterns of communication and relationship. Formational elements such as size and composition may contribute to maladaptive coping patterns (as when a group is too large and heterogeneous to relate to members' intimate problems). The group fulfills its function through the development of a culture and social structure which mediate between group needs and environmental demands; and between individual needs and group demands. It is through the social structure that a network of roles emerges which provides for role-allocation and decision-making. Roles may shift and change; the social structure may be too tight or loose. An individual's autonomy, for example, may be reduced, and social interchange with the environment may be limited in a group whose structure is too tight (Germain & Gitterman, 1980, pp. 212-13).

It is through the social structure, with its relationships and communication patterns, that a group emerges. Through members' values, knowledge and beliefs, the group develops norms with regard to rights and responsibilities, and develops styles of work, relationship and communication. When group norms are ambiguous or unevenly enforced, discrepancies arise which may create maladaptive communication patterns and relationships (Germain & Gitterman, 1980, pp. 213-15).

Maladaptive interpersonal patterns may emerge as

(a) *factionalism*, where alliances may undermine the security and status of non-affiliated members; (b) *monopolism* of the manifest group process by one member, which undermines the purpose and task achievements of the group; and (c) *scapegoating* of one member with the consequence that some manifest group issues may be suppressed (Germain & Gitterman, 1980, pp. 215-17).

It is through a multidimensional understanding of a family or formed group that data and impressions about structure and process are gleaned. It is with the participation of all members that structure, norms, values and goals, as well as maladaptive interpersonal patterns are explored and worked within the process of assessment and intervention. The worker defines the problem in transactional terms as being located in the system or a subsystem, and not in any one individual (Germain & Gitterman, 1980, pp. 219-20).

The worker may utilize enactment techniques such as role play, role reversal, soliloquy, or role enactment of an event; 'sculpting' to create a person's physical-structural representation of a relationship; and cognitive tools such as the genogram, the ecomap, between-session assignments to clarify or improve relationships and communications; and audio- and videotape to enable members to observe themselves in a session (Germain & Gitterman, 1980, p. 239).

In the *ending phase*, a termination which is related to the helping process, along with mutual, client-worker evaluation, makes for a sense of closure for both client and worker (Germain & Gitterman, 1980, p. 18). The authors outline a four stage termination process, although every client may not go through each stage. The decision to end may be mutual, or imposed by the nature of the setting, as in the ending of a hospitalization. It may represent the end of a planned short term service; or it may be brought about by unexpected events, such as illness of client or worker. Regardless of its origin, termination poses specific tasks for worker and client (p. 255).

It begins with the worker's *preparation* in a review of her knowledge of the client, the client-worker relationship, and their respective experiences and methods of coping with separation. She anticipates both her own and the client's reactions. Temporal, organizational, and modality factors may bear on the anticipated ending. A permanent separation may or may not mesh with an agency's temporal structure, such as the ending of service in a school setting at the end of, or during an academic year. Disclosure of a student worker's status prepares both client and worker for a separation date, as does planned short-term treatment. Termination may induce less stress in family and group modalities when members retain the relationship to one another after a worker's departure. Preparation and anticipation of the loss of valued attachments may clarify positive outcomes

and increase the possibility that someone will seek service again, when in need (Germain & Gitterman, 1980, pp. 255-60, 292-4).

Four stages of separation are described. (a) *Denial* may serve as an adaptive maneuver to ward off anxiety, and give the person time to take in the meaning of a loss. It is followed by intense (b) *negative feelings* in various forms, including physical symptoms, self-destructive behavior, regression, excess dependence and anger at a projected experience of the worker's incompetence--all of which the worker, in an empathic and detached mode, accepts as real to the client. Once these feelings have been successfully confronted, there may be a freedom for worker and client to experience a shared (c) *sadness* about the separation. There are three tasks in the (d) final *release* stage which allow the client an opportunity to integrate the service experience. These are *recognition* of gains and of uncompleted work; development of *future plans* such as termination, transfer, referral or self-directed tasks; and *final goodbyes and disengagement* (Germain & Gitterman, 1980, pp. 260-70, 292-4).

Finally, *evaluation* involves the worker's assessment of outcomes, with identification and explanation of what was and was not helpful. When practice is based on mutual agreement between clients and worker with regard to problem definition, goals, planning and action, it tends to be easier to assess outcomes with clients. Evaluation adds to knowledge, to accountability of worker and agency to clients, to regulatory and funding bodies, to

research questions and to agency service (Germain & Gitterman, 1980, pp. 278-94).

Germain and Gitterman (1980, p. 297) discuss the worker's professional influence in the agency, with an eye toward improvement of the goodness-of-fit between needs and services

They examine the external and internal effect of societal, professional and bureaucratic forces on the agency. Social values and norms affect human service organizations, for example, via private or public funding and regulatory bodies, and available financial aid to the poor. Such aid may be punitively given. An agency may be out of touch with contemporary social needs, and be unable initiate programs. Professional interests and ideology may conflict with those of clients, especially if an agency is fraught with competing interests and internal struggles (Germain & Gitterman, 1980, pp. 297-300). "Interdependent societal, professional and bureaucratic forces can create practices" which are self-serving, "at the expense of client interest" (p. 300). It is in three related areas that client problems tend to originate. (a) *The agency's definition of its services and purpose* may pose a problem for client utilization, if need and problem are seen as existing within the client, so that external factors get little attention. Such a problem definition may reflect professional preferences, perhaps with ensuing (b) *structures and procedures* which are unresponsive to client needs. The agency unit designed

to cope with community and bureaucratic forces may instead delegate such authority to staff and show little leadership.

(c) *Service arrangements* may then be inadequate or inaccessible (pp. 300-2).

It is seen as a social worker's responsibility to maintain a watchful eye on organizational processes which have a bearing on services to clients. When problems arise in these processes, the worker must try and modify them (Germain & Gitterman, 1980, pp. 300-2). The authors have enumerated a five-phase procedure through which the worker may influence her agency to be more responsive to the needs of its clients. It is through attention to clients' expressions of need, review of records and other data, and attentive listening to colleagues that a worker begins her (a) *preparation phase with problem identification*. She considers *possible solutions*, and tentatively identifies a *change objective* and particular *means* through which to attain it. She then begins a formal (b) *initial organizational analysis* by assessing which *environmental forces* and *interpersonal forces* are likely to be supportive and constraining of the plan. She also assesses her own influence. After she is satisfied in having sufficient information, the worker targets appropriate *points of entry* for the change effort. In the (c) *entry phase* she prepares to influence the organizational structure (especially the informal structure) toward responding favorably by positioning herself to influence the system by her competence, her influence upon others, her

appropriate use of client feedback, and the management of stress to which she has heightened in her getting agency personnel to focus on the problem. (d) The *engagement phase* involves the worker's use of *demonstration*, especially for problems related to professional function and program; *collaboration*, notably in "open" agencies where there we find goal consensus, as well as even-handed resource distribution or staff personal relationships; *persuasion*, where power is unevenly distributed, and where there is no overall goal consensus; and *conflict* utilized with caution and attention to inherent risks, notably when adversarial actions may be called for in the face of sharp dissent about goals and methods. The achievement of a desired outcome calls for the phase of (e) *implementation* and *institutionalization*. This stage may be undermined by negation, delay, or scaling down by agency executives who may be uncommitted or opposed to the change. Other impediments to implementation may be in slow "organizational machinery," incompatibility of the change with existing agency structure, and unclear or opposed staff who distort the change in carrying it out. Finally, "when the change in an organization's purpose, structure and procedures or service arrangements is no longer perceived as a change, but [rather] as an integral part of its ongoing activities," the innovation is considered to have been *institutionalized*, and a stable staff member is handed the responsibility for its maintenance (Germain & Gitterman, 1980, pp. 303-39).

Toward Integrating the Person Focus

Ideas from Ego Psychology.

Germain (1978a) sets out to identify similarities between ego-psychology and general systems theory by translating the latter into ecological concepts, and then connecting these to ego theory (p. 535). Given ecology's concern with adaptation and the relations between organisms and their environments, Germain assumes its natural affinity with ego psychology, whose focus is on adaptation and relationship of the person to the environment. She declares that "general systems theory, the ecological perspective, and ego psychology call attention...[to] the importance of the environment, and to the complexities of its relation with human development and functioning" (p. 548). Included are (a) conceptions of adaptation, and an (b) equating of the presence of stress with a lack of growth, or even of disorganization, when environmental nutriment (biological for the species and psychological for the ego) is inadequate. Also included are (c) the concepts of dynamic equilibrium (in systems theory), goodness-of-fit or adaptation (in ecology), and epigenetic development with cogwheeling of generations (in ego-psychology). Finally, (d) the concepts of negative feedback and equifinality in general systems theory and ecology are likened to autonomy, self-regulation and reciprocity in ego-psychology (pp. 539-49).

Mishne (1982, p. 550) proposes a route toward integrating ego psychology with an ecological systems approach. For Mishne, a clinician's focus on understanding ego functions and development in the intrapsychic system enables her to understand a client's ability to negotiate (transact with) other systems. The ecological-systems approach, says Mishne, fails to recognize psychoanalytic theory as explaining normal as well as pathological development.

Germain and Gitterman (1983) restate that the life model in no way denies that personality is important in social functioning, "nor does it fail to consider and to help with the internal pain of anxiety, guilt, depression, despair, helplessness, self-hatred...and the consequences of such pain for social functioning." They stress that the life model reconceptualizes that problems in living which arise in some instances from maladaptive exchanges with past environments, may lead to dysfunctional psychological states which are perpetuated through exchanges with current environments.

Goldstein (1986) holds that ego psychology's "emphasis on normal coping strategies, adaptation, mastery, competence, cognitive processes, person-environments transactions, biopsychosocial factors in development, and the impact of life-stresses and social change holds enormous promise as a unifying theoretical underpinning for a distinctive conception of social work practice." She continues that refinements which deal with "interpersonal relationships and internalized object relations in normal and pathological ego development have provided an

in-depth dimension for understanding human behavior" (p. 380). In a focus that is specific to either person, environment, or their matching, Goldstein illustrates how ego assessment may help a practitioner determine whether interventions might be directed toward "[a] nurturing, maintaining, enhancing, or modifying inner capacities; [b] mobilizing, improving or changing environmental conditions; or [c] improving the fit between inner capacities and external circumstances" (p. 389). Goldstein elaborates on ego-supportive approaches which call for differential conceptualization and application of inner deficits and resources, relationships, and environmental conditions and opportunities, in individual, family and group interventions over time (pp. 392-7).

On the Ecological Context for Human Development and Interaction.

Bronfenbrenner, in The Ecology of Human Development, (1979, p. 22) utilizes principles of Lewin's topology of life space, ecology and systems theory to present a framework for human development and interaction in an ecological context. He cites Lewin's equation that $B=f(P,E)$, and notes little emphasis on the "environment factor" in psychological studies of human development. With emphasis on a person's perceived reality, topologically represented as life space, he defines the ecological environment. It is a nested arrangement of concentric structures, each contained within the next, in which people relate reciprocally to one another and to their physical environments over time,

through transactions in relationships which may be proximal or distal, direct or indirect, and physically present or cognitively evocative. He specifies three levels of system hierarchy, micro-, meso- and macrosystems, (with four types of system) which for Greif and Lynch (1983, p. 58) divide the realms of "person, family, group, community, society, culture and institution into operationally defined areas." For Glossup (1988), Bronfenbrenner's focus on the person's immediate settings and their larger contexts is basic to an ecological frame of reference.

The "pattern" of *activities, roles and interpersonal relations* which a person experiences in a given *setting* (which includes physical characteristics) constitutes a *microsystem*. Examples are a family or a class at school. A *mesosystem* represents "a system of microsystems" in which the person participates, as in "relations among home, school, and neighborhood peer group." An *exosystem*, whose level of hierarchy may be that of micro- or mesosystem, involves one or more settings in which events affect or are affected by a person who is not an active participant. For a child, this may be a parent's workplace or a schoolboard's activities (Bronfenbrenner, 1979, pp. 22-5). The *macrosystem* refers to overarching ideological, institutional and organizational patterns (8) in a culture or subculture which reflect the content and form of its micro-, meso-, and exosystems, and the beliefs which underlie consistencies among its systems (p. 258). Examples include "system blueprints" for a classroom in the United States as

opposed to France, or for home and day care centers for well-to-do versus poor families in each country. "Intrasocietal contrasts" of "socioeconomic, ethnic, religious...subcultural groups are macrosystem phenomena" (p. 26).

The importance of the interrelationships among people and environments and their shifts is recognized. *Interpersonal structures* are reciprocal interpersonal units such as dyads (or N+1 systems), and larger units (N+2 systems) which generate the "second order effects" of a *social network* when all participants are not present at the same time and place. The distribution of power among relationship participants changes over time as a person develops. The concept of *role* involves a context for reciprocal interpersonal expectations, "a set of activities and relations expected of a person occupying a particular position in society, and of others in relation to that person" (Bronfenbrenner, 1979, 6-7, 85). *Molar activity* represents a continuing process of events which are directly, reciprocally interactive, or internally evocative of past or planned interactive events, and are environmentally related. Examples are building a tower of blocks or conducting a phone conversation (pp. 6-7, 45-8). *Ecological transitions* represent shifts which occur when "a person's position in an ecological environment is altered as a result of a change in role, setting, or both." They instigate and are affected by developmental processes; and "are a joint function of biological changes and altered environmental circumstances; thus they present

examples par excellence of the process of mutual accommodation between the organism and its surroundings that is the primary focus of...the ecology of human development." These can occur at any system level of the environment. Examples are birth of a younger sibling (micro-system transition), or a visit to a friend in another culture (across macro-system boundaries) (pp. 26-7).

Difficulties in operationalizing an ecological framework for human development are highlighted by Garabino (cited by Glossup, 1988, p. 9): "Almost *everything* in the context of development is variable, almost nothing is fixed." Glossup (pp. 9-13) notes the complexity of Bronfenbrenner's building upon Lewin's phenomenological life-space of the person. Glossup sees the framework created by Bronfenbrenner as integrative for abstract bodies of knowledge, each aspect of which informs us of a partial dimension of human experience and development. Thus, for Glossup (p. 13), Bronfenbrenner provides us with "a formal theory complete with a conceptual language, [thirteen] theoretical propositions, and [fifty] empirically verifiable hypotheses."

Challenging Ideas about Human Development.

Germain (1987) advances ecological concepts about human development in our contemporary world. She examines the applicability of biology's phylogenetic metaphor to stage models of social development which embody "questionable assumptions" (pp. 565-6): (a) Stages, life-tasks and valued outcomes are seen as

universal regardless of "culture, race, ethnicity, social-economic status, gender, sexual preference or disablement." (b) A fixed, epigenetic sequence of stages derived from embryology may not apply to social and emotional development. (c) Focus on the significance of mother over father in the first year of life may not hold up to research findings on the "genetic, biochemical, and neuro-physiological aspects of some psychopathologies" (p. 566).

Germain (1987, p. 567) proposes *cohort theory* and the concept of *life course* as alternate models through which to see human development. She explains a birth cohort to consist of all persons who having been born at a particular time, were exposed to the same sequence of social and historical shifts at the same ages. The experience, notions, attitudes and values about collective life and personal aspirations of the members of a particular birth cohort thereby differs from that of any other birth cohort, such as those persons who went through adolescence in the 1950' as opposed to the 1980's; or those who had become elderly in 1900 as opposed to those who will attain such age by the year 2,000. "Cohort" and "generation" differ as concepts. The latter defines a kinship context for cohorts of specific persons or families. One cohort's members do not follow the patterns of preceding cohorts as they move through the developmental process. Size and life conditions of cohorts vary. There may be less competition among members of smaller cohorts for the same opportunities. "Sex ratios within cohorts bear upon opportunities

for pairing and parenting. Thus, development is relative to culture and is also time-bound."

Cohort theory is seen as transactional over time. Each cohort is affected by its predecessors' marks, and each leaves its imprint for future cohorts. With reference to Riley (1985), Germain (1987, pp. 567-9) describes how a different context for development exists for each sequential cohort. With the contemporary increase in the rate of social change coexisting cohorts display marked differences, each having its own unique experience," norms and agenda for institutional change. In a direct reference to Mead's discussion of "Prefigurative Cultures and Unknown Children" (1970, pp. 64-97, 84), Germain (p. 568) notes how differences are so radical between cohorts that parents worldwide can no longer foresee their children's future lives, and children can no longer imagine what their parents' lives were like in childhood.

Germain cites Riley's (1978) admonition against cohort-centrism. Germain (1987) notes that the stage models of Freud and Erikson emerged from their clinical experience with patients with whom they shared a *zeitgeist* (p. 568). She sees the new interdisciplinary concept of *life course*, developed collaboratively by sociologists, anthropologists and historians, as fitting with cohort theory. Life course conceptualizes development over individual, family and historical time. Life transitions are "person-environment processes rather than isolated...[or] predetermined ages and stages of experience" (p. 568). In a

citation of Hareven (1982), Germain (pp. 568-9) goes on to state that life course accounts for synchrony between individual life transitions and collective family configurations under social conditions which are changing. She points out that roles and behaviors which were once reserved for particular age or gender cohorts now involve non-traditional cohort-crossovers such as older fathers and men as homemakers.

For Germain, concepts of attachment, affiliation and loneliness serve as alternate ways of understanding human needs, behavior and relationships.

Germain (1987, pp. 571, 578n) distinguishes object relations theory from *attachment theory* as developed by Bowlby. She notes that object relations theorists refer to attachment as synonymous with object relations, which "arise gradually out of the libidinized feeding relationship." She also distinguishes attachment from dependency. Bowlby (1973) describes affectional attachment behavior as not only related to mediation of nutrition and reproduction, but to mediation of the needs of a community of species for protection.

Germain (1987, 570) explores the relationship of attachment theory to the development of competence. She cites Bowlby (1973) on *affectional bonding* in which he sees the capacity for developing affectional ties as genetically innate to humans, having been selected into the gene pool by the environment over the course of evolution out of its value in species' survival. Infant

attachment behavior with reciprocal parental caretaking behavior represent affectional bonding which in adulthood is seen in pair formation, sexual bonding and affectional bonding. For Bowlby, a person's seeking the comfort of trusted others is healthy and by no means regressive. Germain (1987, p. 571) cites Weiss (1982) on "Attachment in Adult Life." In her noting how attachment behaviors may vary with culture, she speaks of the importance of adult attachment behaviors including those to peers, "who are perceived either as sources of strength or as supporters of the individual's capacity for mastery." Attachment theory, for Germain (p. 571), emphasizes the significance of primary attachments over the life course, as well those of "social networks of kin, friends, workmates, neighbors and so on."

Germain (1987, pp. 571-2) cites Weiss (1973) on loneliness to distinguish attachment from *affiliation*, also important in adulthood. *Emotional* isolation and loneliness, a result of loss of a primary attachment figure (as in death or separation), must be relieved by development of another such attachment, following a completed mourning process. Relief from *social* isolation and loneliness, due to loss of affiliation (as in migration or job loss), requires membership in another network of affiliation with mutual interest and support. Germain cites Bowlby (1973, p. 45), as well as research by Ainsworth and Bell (1974) and by Sroufe and Waters (1977), to explain that a child's attachment security, which involves mother's available presence for a young child (sic), as

an organizer of behavior correlates with greater freedom in environmental exploration, and promotes a positive self-concept with belief in one's own competence. These findings are, for Germain, congruent with White's concepts (1959) of inborn *effectance*, the experience of *efficacy*, and the sense of *competence* "that one can affect one's environment."

In findings from Stern's infant research, (including, 1977; 1985, pp. 11, 47-8), Germain (1987, pp. 573-5) highlights evidence of the newborn's genetically responsive predisposition to the human face, voice, and body, in its intrinsically responsive and capable nature, and its innate ability to coordinate knowledge between sensory modalities. Stern concludes that a consistent confusion between self and other by the infant through a long stage of symbiosis is unlikely.

Germain (1987, pp. 575-6) cites research and writings by A. Thomas (1981), by A. Thomas and Chess (1977, 1980), and by Chess, Fernandez and Korn (1980) which characterize the human brain's flexibility and plasticity, which impart a unique capacity for human learning during the life course. Plasticity is seen as enabling physically handicapped children to find alternate pathways in development which are congruent with their capacities and limitations, and which may indeed be out of sequence or different from what is specified cognitively and emotionally in stage models development. Thus, the brain's plastic potential holds forth promise of corrective change, so that inadequacies in

early care which may have significance are not automatically seen as causing irreversible damage. It is implied that stage models of early life experience do a disservice to the potential and resilient qualities which are human, and to the importance of development as a context throughout the life course.

Two non-stage models of development of the full life course are cited. Bronfenbrenner's (1979) model recognizes the influences of biological and cultural factors, and the psychological processes of perception, motivation, emotion, thinking, and learning but has not specifically incorporated these into its framework which focuses on development (a) at various levels of ecological context (from dyads to large units) (b) via ecological transitions. Stern's (1985) model of lifelong development of "four senses of self" and "four domains of self/other relatedness" replace notions of critical periods and predetermined stages. For Stern, a problem in living can emerge "in any sense of self or domain of relatedness at any point in life," without necessarily reflecting an early psychogenic experience which must be dealt with for a successful outcome (Germain, 1987, p. 576).

In summation, Germain (1987, p. 577) notes the need for continued exploration of the importance of "nonuniform pathways of individual development and collective life in contemporary society."

Toward Integrating the Physical Environment Focus

The role of the physical environment in human behavior has traditionally been given little emphasis in the "psycho-social" view of social work. Some recent conceptions are cited which are intended to reflect seminal ideas about the role of the physical environment in human interaction and social work practice.

Germain (1978b) addresses the man-made physical environment in a review of *space* as a physical and psychological construct in an ecological practice framework. Space relates to status and social interaction, and to cognition and perception (p. 515). Emphasis is on reciprocity "between the social and physical environments and their interaction with culture, personality, and behavior" (516). She describes the place of man-made space in (a) human development, (b) dwellings and (c) behavior.

1. Spatial styles in *human development* involve "perceptions and conceptions of distance, direction, density and vertical-horizontal, left-right, up-down orientations" (Germain, 1978b, p. 516). These arise in childhood through culturally patterned action and interaction with and upon the environment, and involve an internalization of aspects of spatial organization, as well as a developing awareness of self from non-self, inner from outer space, in the experience of distance and separation from mother, in a reciprocal and ever-widening, social circle of the child. Since social experience occurs in physical surroundings, we might see

life-space as expanding in childhood, adolescence and adulthood; and contracting in old age. Germain cites (a) the intrusiveness of a young child who works on issues of initiative in the exploration of others' space; (b) the territorial relations of the school years characterized by peer in-groups and out-groups, with increasing distance between child and family as he reaches into "space occupied by school, recreational organizations, neighborhood" (p. 517); and (c) the adolescent expansion of peer territories into widened variety of home-ranges, including secret physical and inner spaces, with more distance and autonomy from family; to (d) the adult "habitat of dwelling, neighborhood and community [which] must provide a physical environment capable of supporting the full range of human needs and interests as they evolve biologically and culturally." Germain continues that distorted behavior may occur where appropriate settings are unavailable, and where lack of fit between human needs and spatial characteristics impedes successful resolution of life tasks (p. 518).

2. The *dwelling* encloses interior space and excludes outside space. It reflects how people see both their interior intimate selves and the public facades shown to others. Germain (1978b, pp. 518-20) cites Cooper on "The House as Symbol of the Self" (1976), to highlight the issue of threshold between private and public space and its cultural origins. Examples are cited by Germain of spacial arrangements and behaviors which interfere with growth and development. These include the hidden thresholds

and closed interior doors of a home, which interfere with nutritive interchange both between a family and the outside world and among its isolated members; or a lack of semipublic space in a public housing project which interferes with the development of informal networks around which supports, mutual aid or social contacts of lower- and working-class neighborhoods could coalesce. She notes the importance of the interaction between physical and social environments. In impoverished service facilities, staff and residents may become used to inflexible physical structures, which with simple modifications might personalize and humanize a setting, to enhance a client's individuality, dignity, and autonomy. She refers to a poor fit between client needs and activities, and the physical environment as a *setting deprivation*, in which a space is *not* experienced as a place which is part of one's sense of identity, autonomy, and social competence.

3. The active use of the physical environment in one's functioning constitutes *spacial behavior*. Germain (1978b, pp. 520-22) brings together conceptions of Henry (1973, pp. 36, 76), Kantor and Lehr (1975, pp. 66-77)⁸, Altman (1975)⁹, and others to lay out the behavioral use of the physical environment (a) in maintenance of territorial boundaries and the regulation of distance/closeness among family members; (b) in the "interaction between internal forces of perception, cognition, and emotion on the one hand, and the spacial features of the physical setting mediated by the social environment and the culture, on the other;" (c) in the understanding of the unpleasant psychological-social

states of crowding and isolation; (d) in the concept of personal distance as an individual's spacial bubble, a buffer or shell which, with cultural meanings, may enhance or interfere with adaptedness; and (e) in the importance of socially set territorial markers to provide cues to people about role relationships toward enhancing the stability of social organization, and how these markers may be built into housing design to facilitate development of mutual aid responses both for security and social interaction.

For Germain (1978b, p. 522), spacial behaviors reflect a person's adaptive potential in transaction with the spacial aspects of the physical environment. Supportive environments facilitate growth and adaptation; depriving environments induce stress to impede growth and adaptive functioning.

A distinction between natural and man-made environments is not so easily rendered, as Wohlwill (1983) shows. Some distinctions are gross, as those between the realms of (a) rock, sand, shoreline desert, woods mountains, and plant and animal life; and (b) "cities and towns, houses and factories, as well as tools and implements for human needs." The value, purpose and legitimacy of distinctions between the two realms, and between the differential human responses to each is an issue raised by Wohlwill (pp. 6-7). He illustrates "boundary-line problems" in differentiating these realms with images of a natural and an artificial lake, whose distinguishing marks might be clear only to biological and geological scientists (pp. 7-12).

Wohlwill (1983, pp. 12-19) proposes a *perceptually based* ecology of natural environments through which it would be possible "to identify a set of stimulus attributes in terms of which natural environments may be differentiated from man-made ones" (p. 12). He draws on work in perception to point out that while the artificial world is composed of 'natural' materials, its form tends to differ greatly from forms which characterize the "natural domain." Stimulus attributes include differences in lines, edges, gradations, shapes, colors and textures, which tend to be less regular, more curved, gradual, rough and irregular in the natural world; and more regular, rectilinear, sharp, discontinuous, abrupt and smooth in the man-made world, to the casual observer. He looks at olfactory and auditory differences as well.

Wohlwill (1983, pp. 21-30) considers three other views to distinguish nature from the man-made world. The first, (a) "the notion of nature as a manifestation of...growth and change" (p. 21) extends the stimulus-characteristic framework to encompass our perceptions of change over time (pp. 22-3). The notion of (b) "nature as a refuge" differentiates "our contacts with the world of nature from the conditions of our everyday lives" (p. 25). An individual's getting little acknowledgement of his presence from the wilderness may be at the heart of its restorative powers for some, and provoke anxiety in others who depend on responsiveness from the environment (pp. 23-6). Finally, (c) "nature as a symbol" involves the differentiation of meanings of the natural environment to people in different historical times, or in different

contemporaneous cultures. We see this if we contrast the view of the first white American settlers for whom the hostile environment needed taming, with that of today's environmentalists who praise and protect it. This change reflects not only shifts in people's experience of nature, but also actual environmental changes such as the "reduction in forms of animal life dangerous to man" and the invention of protective equipment for people who venture into natural areas (p. 28). It also reflects the urban decay and suburban sprawl of everyday environments which afford a very different contemporary context in which to evaluate the natural environment (p. 28).

Wohlwill (1983, pp. 30-2), in citing limited research on the developmental origins of the natural/artificial differentiation, notes that children from age six or seven onward respond readily in terms of the "nature" as opposed to "man-made" categories (p. 31). This reinforces the notion, untested across cultures, that the realm of nature represents a "natural" category, and that the capacity to differentiate from the man-made realm is set at an early age.

Wohlwill (1983, pp. 32-5) proposes a research program to locate perceptual, cognitive and affective origins and stimulus determinants of an individual's concept of "nature." The concept's high level of abstraction calls forth an intricate cognitive structure with a rich context of connotative associations connected with it. Wohlwill is, however, clear that while human beings may thrive in rather artificial settings such as the space shuttle, our evolutionary heritage may well underlie a preference

for stimuli from the natural environment of which we are a functional part, and which may never be totally substitute for the man-made environment.

Germain (1983, p. 124) describes the physical environment as a dynamic transacting part of our life space, to which we must adapt, and which we must also use for our adaptive needs. Germain sees what human beings fashion as being *no less* 'natural' than what other species build. (We might think of this in a bird's nest, for example.) For Germain, it is merely convenience which makes this arbitrary distinction useful.

In citing Searles (1960, p. 120fn.) on schizophrenic versus normal development, Germain (1983, p. 124) suggests that the two differ in relation to the natural environment in a manner which parallels differences in relatedness to other humans, such as in the capacity for self- other (parallel to environment-other) distinctions. She states that for Searles, "the years of childhood and youth are spent in differentiating one's self from the social environment of significant others and the physical environment of nature and cherished physical objects." The rest of one's life is spent in working to reintegrate both worlds "while maintaining separateness and individuality." She comments on biologists' doubts of the human capacity to retain physical and mental health unless one remains intimately in touch with the world of nature which has shaped human nature (e.g., Dubos, 1968, pp. 149-51). Fresh air camps for children and mothers, notes Germain, grew out

of settlement workers' implicit appreciation of the natural environment as part of the unit of attention in their awareness of "the needs of inner-city residents for renewal and refreshment in the natural world." Contemporary applications cited by Germain include camping for inner-city families (Vassil, 1978), overnight trips for chronic psychiatric patients (Shearer, 1978), wilderness therapy for delinquent and disturbed youths (Cataldo, 1979), and use of pets for isolated individuals who live alone (Bikales, 1975).

Germain (1983, pp. 125-6) notes how time and space, as dimensions of both physical and social environments, influence behavior and social relationships around the issues of both physical arrangements, and environmental rhythms and cycles which have biological, social, cultural and psychological components which must be accounted for in assessment and intervention planning.

Germain (1983, p. 126) cites Altman's (1975) transactional, perceptual paradigm which suggests that "personal and spatial behaviors" (to which she adds "temporal" behaviors) serve to maintain a chosen degree of openness or closedness of one's self/other boundary and its relationship to the unpleasant phenomenological states of crowding or isolation, with the concomitant experiences of physical and emotional stress. With reference to Draper (1979), Germain (p. 126) notes that among behaviors which control interchange across the self/other boundary are personal distance and territorial behaviors; "nonverbal,

paraverbal, and verbal behaviors." Among environmental interventions one might consider changing the temporal or spatial arrangements in the physical environment so as to make both privacy and sociableness into viable alternatives.

For Germain, (1983, p. 127) "elements of physical and social environments may be analyzed in terms of their potential usefulness for social workers." These include "social networks, natural helpers, mutual aid systems, the natural and built worlds, and relevant concepts of space and time."

Germain (1983) notes that the clinical relevance of the micro-environment derives from ways people experience and take action in it. "The clinical relevance of the interaction between people and their environments may involve (a) changing aspects of the social or physical environments; (b) protecting, supporting, or mobilizing aspects of the environment that support growth; and (c) designing and using environmental instruments of help; adding or subtracting someone or something to or from the life space; or otherwise restructuring life situations" (p. 111). The physical setting, natural or built, shapes the social interaction within it. A setting's social structure influences the use of its physical space and responses which are evoked" (p. 111). Cultural values and norms influence the meaning of nature (as respected or exploited, for example) and can be influenced by the physical and social environment (p. 112).

Toward Integrating the Social Environment Focus

On Reciprocity in Family Practice Approaches.

Walsh (in 1983) looks forward from the early years of family therapy through the early 1980's, to outline several contemporary models of family therapy with varied emphases.

1. *Growth-oriented approaches* include (a) the *psychodynamic-transgenerational model* which, deriving from a psychoanalytic tradition, emphasizes parents' unconscious re-enactments of their own intrapsychic conflicts which originate their early family relationships. A shared process of projections and introjections between spouses, parents, and children is based on respective, complementary needs. The therapist, as a catalyst, encourages awareness of covert, unconscious, intense feelings and shared defenses, their origins and consequences. (b) The *Bowen Family Systems Model* focuses on differentiation of individuals from family of origin--with genogram work in at least three generations. In (c) the *experiential approaches*, the therapist is a facilitator to diminish propagation of old pains in current interactions, through change efforts which correct self-worth, communication, systems processes and family rules (Walsh, 1983, pp. 473-6).

2. The *problem-solving approaches* include (a) the *structural model* which emphasizes the patterning of interrelationships between a person's behavior and his environmental context. It focuses on structure, subsystems and boundaries. When transactions are repeated, they form patterns which create the structure of the

family. Symptoms indicate an imbalance in the organization of a family, notably in the its hierarchical arrangement with a lack of clarity in parent and child subsystem boundaries. This may be a maladaptive reaction to new environmentally-induced needs. The action-orientation of structural family therapy is founded on a belief that behavioral change takes place independently of insight by family members. (b) *Strategic and Systemic Models* also have a base in communication theory. Focus is on the current social situation of an identified client through which a presented problem is seen as an act of communication. The therapist works to state the problem in behavioral terms which are solvable through directions and paradoxical instructions designed to alter the cycle of feedback which maintains behavior symptoms. In (c) *Behavioral Learning Approaches*, emerging from behavior modification and social learning traditions in clinical psychology, social reinforcement depends upon is adaptive behavior as opposed to symptomatic or maladaptive behavior (Walsh, 1983, pp. 476-9).

3. *Other approaches* include (a) *multiple-impact approach* (Langsley and Kaplan, MacGregor and others) where all members of a family join to meet with a team when one member is in crisis to strengthen coping capacities and mobilize health-oriented interpersonal processes. Use of (b) *multiple family groups* provides mutual learning and support toward facilitating integrated readjustment of hospitalized psychiatric patients and their families. (c) *Social network intervention*, was "developed by Speck and Attneave from their appreciation of the value of tribal

meetings for healing purposes in many cultures." "The intervention team convenes a meeting of all members of the kinship system, friends, neighbors, and everyone of significance to a family presenting a problem," based on a view that people can better deal with crises "when they can share coping strengths with others in their natural social networks" (Walsh, 1983, p. 480).

Walsh (1983) notes that "most current teachers and practitioners of family therapy attempt to combine or integrate family therapy models" (p. 481). All approaches "focus on direct assessment and change of the relationships among individuals, rather than [on] problems "inside" the individual symptom bearer or derivatives in transference phenomena. This is perhaps the major distinction of the family systems orientation from traditional individual treatment models." Transference has a diminished role because family relationships are present, first-hand, in the treatment room; and when they occur, states Walsh, "are redirected for expression and change back into the natural relationship network." The therapist, by attending to the system, "can anticipate reactions to change and has more power to alter symptom-maintaining patterns," which impact intrapsychically on individual family members; and change in particular members has potential benefit for all, not merely the symptom bearer (p. 484).

While family and group treatment both focus on the collective and its communication processes, family therapy stands out for Walsh, in its "convening [of] the natural relationship unit that has a shared past, ongoing interaction, and future, as well as its

own values, goals, language (verbal and nonverbal), and loyalties" (Walsh, 1983, p. 484). It is defined by its systemic focus. In some cases, as in Bowen's model, individual sessions may be utilized to plan for change in the system (p. 484). Walsh refers to family therapy not as a single approach to treatment, but instead as "a flexible model that can be tailored to fit specific client needs and treatment situations," and where "contracts and objectives are explicitly formulated with families, and strategies and techniques follow a clear direction, based on a sound assessment of the family system" (p. 485).

Hartman and Laird (1983, pp. 27-9) outline contemporary views and definitions of family. Traditional social science definitions structurally define *nuclear* and *extended*, to *legal*, *conjugal*, and *consanguine* relationships. With Richmond's definition of family (cited by Hartman and Laird, p. 28) as "all who share a common table," they contrast notions of "family" with those of "household." The latter allows for crossovers between the family and nonfamily boundaries of our contemporary society. The functional approach of sociology, which sees the family in terms of its functions, such as child-rearing, meeting of adult affectional needs, and social value transmission, has unresolved issues about the functions families carry out. They cite Speigel (1971, p. 144) who, in a search to define "family," saw great varieties of structures and functions, so that any study of the family must refer to the social and cultural contexts in which it is located.

Hartman and Laird (1983, pp. 29-31), in seeking definitions of family which, like Richmond's promote a pluralistic perspective, elaborate on two categories. *Family of origin* accounts for biological roots and consanguine relationships in one's vertical (multigenerational) and horizontal (kinship) blood, adoptive and fictive ties. The *family as the intimate environment*, a functional concept, is built on marriage, parenting, or other mutual decision by two or more persons to contemporaneously share needs for living space, closeness, and roles and tasks, to meet biological, social, and psychological needs of people in an intimate network.

Hartman and Laird (1983, pp. 72-4) see principles of the ecological metaphor as providing guidelines for family-centered practice. This includes the conception of "problem" or "need" in terms of (a) environmental deficits, "dysfunctional transactions" between systems, dysfunctional adaptive strategies, or interrupted growth, as opposed to disease within the individual; and (b) "outcomes of the transactions of many complex variables," in a "feedback model of change," rather than reflective of linear causation (p. 72). Additionally, (c) life experience provides a model and "primary instrument of change" (pp. 72-3). (d) Change in one system part impacts on all system parts, so that a minor intervention can produce a major change, by stopping or reversing a deviation-amplifying process in a system (p. 73). (e) Action principles include the notions that *natural means* are preferred over *artificial means*; the *least intervention* with potential to achieve the objectives is preferred (which could include preference

for short-term treatment over long-term help); and a *variety of means* may be utilized to produce a particular effect, which is the principle of "equifinality" (p. 74).

Hartman and Laird (1983, p. 157) discuss the family in its ecological context. They compare the role of the ecologically-minded social worker with that of the shaman, healer of many cultures. Each is seen as cognizant of powerful influences and interplay among individual, family, culture and environment. Each takes note of the individual's distinct but not separate psychic and physical realities which interact to influence one another in all action. A shaman provides avenues for "confession, atonement, and restoration" of a person into the family and tribe. He may assume varied roles such as "physician, magician, priest, moral arbiter, representative of the group's world view, agent of social control, or initiator of change." Both shaman and ecologically-minded social worker may share a focus on the complex interrelationships among physical, social, psychological, and cultural forces, and see these "as influences in the production of disease, deviance, and dysfunction...."

Hartman and Laird (1983) discuss the *eco-map*, originally developed by Hartman as a tool for in public child welfare workers to use in examining the needs of families. Its visualized boundaries enclose the individual or family in the life space which includes the major systems and all their interrelationships which reciprocally bear upon the subject. It shows the flow into and out of a family system of resources and energy. Its rendering is

a shared worker-client process and encompasses concrete life connections, as well as connections "to those human, personal, psychological, social, and spiritual influences which also shape our lives." The eco-map highlights "deprivations which may erode family strength." As it is developed, "family and worker should be able to identify conflicts to be mediated, bridges to be built, and resources to be sought and mobilized" (pp. 158-9). An assessment of family needs and environmental resources to meet these is drawn up to cover specific needs such as nutrition, shelter, protection, health, belongingness and intimacy, communication and mobility, education and enrichment, resources for the spirit, autonomy with effectance and mastery, and generativity (164-6). With the aid of the eco-map, questions are considered about the family's relation to (a) the ecological environment, (b) the family-environment boundary, (c) the internal family system and subsystems, and (d) the worker, agency and service network (pp. 166-71). Examples are given of work with (a) a deprived family, (b) an overburdened family, and (c) a socially isolated family (pp. 171-84). The value of the eco-map, note the authors, "hinges on its usefulness as a blueprint for carrying out planned change." Its retrospective use may highlight changes which might have earlier precipitated current difficulties (pp. 184-6).

In synchrony with the ecological metaphor, Aponte (1979) illustrates the use of "diagnosis" (or assessment) in family therapy as an ongoing process, not a product, in the

understanding of a family's structure by focusing on relationships and communications of subsystems and their members. Diagnosis in family therapy for Aponte, means understanding a human behavior module in its own ecological context (pp. 109-10). It allows a clinician to see how forces converge in a context to produce an action at a particular moment in time. The structural family therapist, for Aponte, "utilizes the ecological context as the framework for his or her diagnostic effort" (p. 110).

The therapist seeks information to the extent that it may help to solve the problem at hand, stopping short of comprehensive study. Forces which have created a problem are deemed to be active in current behavior and transactions. Thus, she works to create a context in which central structures will be "reexperienced and reenacted among family members and with the therapist." Furthermore, each intervention during the course of treatment is seen as flowing out of a progression of diagnostic hypotheses about the individuals and their relationships within and outside the family as these bear on the problem at hand. Hypotheses are put aside or confirmed. If they are confirmed, it will be important to elaborate on them during the therapy (Aponte, 1979, pp. 110-12).

In an interview, Aponte (1979, pp. 108-9) focuses on the subsystems of father and sons to support father's understanding and leadership role; on the sibling subsystem to enable brothers to deal with one another supportively; and on the spouse subsystem, to help the wife see and support her husband's

strengths. As Germain's introductory statement to Aponte's chapter points out (pp. 107-9), Aponte's interventions are geared to alter the system's structure, so as to allow transactions among system parts to shift in a positive direction. Aponte's use of task to engage family members directly with one another in session and at home is quite clear.

Hartman (1979) sees the extended family as a resource for change. "The family," she writes, "is a powerful biological, emotional, and social system that exists in space and through time" (p. 242). It is through the family that we come to do what we do and become who we are. Yet, "much of the impact of the family system exists outside of awareness, not because it has been necessarily repressed or relegated to the unconscious, but because it is so much a part of the self" (p. 245). A major goal of treatment for Hartman is helping the individual "begin to remove obstacles to growth, to become increasingly different from the family system, and to move to a higher level of differentiation." She goes on to say that "people who are sufficiently differentiated can be away from their families without emotionally cutting themselves off, and can be close to their families without becoming lost in the system" (p. 244). Toward this end she conceives of helping the member(s) to objectify family proscriptions, "to step outside of the system so that...family rules can be recognized in the family and in the self" (p. 245). The method is a step-by-

step, time-consuming task of fact-gathering about a family over time, while organizing the data with client(s) through the joint construction of a genogram which becomes a tool for understanding (pp. 247-58). She explores intergenerational identification toward understanding connections between members of the current family and those of the family of origin via sibling order, family expectations, themes and heroes and heroines (pp. 256-7).

The general goal, a diffusion of tensions in nuclear family by means of opening channels into the extended family, is seen by Hartman (1979, p. 262-4) as a general phenomenon. The use of "the extended family system as a resource for and arena of change is one way of translating ecological principles into practice" (p. 262). The person is seen as being in the family, and the family is seen as being in the person. "The focus of study and of intervention is on the transactional relationships between the person and the family in space and through time and the assumption is made that a change in either family or person will bring about changes throughout the system" (p. 263). Hartman conceptualizes this in systems terms, noting that continued differentiation is a natural occurrence when living systems remain open. The worker's role in an egalitarian power relationship is to help the client(s) in (a) objectifying the family system, (b) identifying, planning and rehearsing change strategies and (c) discovering and overcoming obstacles to change (263-4).

On Reciprocity in Networks, Mutual Aid and Mediation through
Group Processes.

Swenson (1979, pp. 214-15, 233-5) describes conceptions of social networks and self-help/mutual aid as presenting opportunities to reformulate in an ecological perspective certain basic practice elements which are vital for the development of any practice model, including the life model. The concepts are (a) problem definition, (b) view of the person, (c) worker-client relationship, (d) goals of helping, and (e) service delivery arrangements. The concept of mutual aid is seen as cutting across these five elements in its tying network theory integrally to the life model.

Swenson (1979, pp. 215-17) highlights various kinds of primary groups in which emotional bonds, as opposed to merit, are implied basic determinants of membership. She cites studies which demonstrate (a) vigorous existing *extended family groups* in working class industrial urban society; (b) primary-group-like "*work groups*" for whose members self-image, success and vitality of relationships are invested in the group; (c) *friendship and support groups*, and by extension (d) *neighborhood groups*, exemplified by apartment building groups for adults and (e) local, informal *play groups* for children; and (f) the inclusion by people in their primary-group-like collectives of *local professionals in membership*, such as a competent doctor or a fair-minded welfare worker. Swenson cites Litwak and Meyer's point (in Swenson,

1979) that such "primary social groups and formal organizations can exist in interdependence and maintain their uniqueness and strength" (Swenson, 1979, p. 217).

The flexible boundaries and interconnected qualities of varying magnitudes suggested by the idea of network, for Swenson (1979, p. 218) refers to the subjective community of persons, groups and parts of institutions that have meaning for us.

A major function of network is *mutual aid*. It includes *instrumental support* (assistance in task accomplishment and resource provision), and *nurturance* (which includes various forms of emotional support). The full network or a part of it may provide a person with a meaningful focus (Swenson, 1979, p. 223-28).

Germain (1983, pp. 119-20) sees growing professional interest in social networks based on the importance of attachment bonds in human development. The loneliness inherent in social isolation can be relieved only by engagement in a social network. An example is cited in widow-to-widow programs in which new widows are able to receive support and guidance from peers who have faced similar situations and tasks, although the pain of the loss itself certainly cannot be relived in any substitute attachment. She sees social networks, systems of mutual-aid, self-help groups and natural helpers as environmental instruments which are vital to primary prevention as well as to restorative interventions.

Germain (1983, p. 121) continues that experience suggests that two human motives are involved in natural helping systems. The first motive, *altruism*, is described by E. O. Wilson (1978) as basically genetically determined with its intensity and form being shaped by culture. For other biologists it is described as learned by humans in their social environment. The second motive is the *need for reciprocity*, to give and receive, which is to help oneself through helping others. Reciprocity, through self-help groups and professionally led formed groups, is seen as making possible the success of mutual aid "among kin, friends and neighbors."

Lee and Swenson (1986, pp. 361, 368-9) elaborate on the concept of mutual aid. They cite the "generic vision" of Schwartz (1961) which emphasizes mediation, skill, process, affect, reciprocity and the mutual aid enterprise of the group. They elaborate on related conceptions. Informal *social support* is differentiated from professional help through formal agencies. It is seen as being of great influence on the outcomes of problem situations of high stress and crisis. The "*helper therapy*" principle emphasizes the enhancement of effectiveness, competence and maturity of the non-professional helper who, as a client, is helped by helping others. Self-help groups, note Lee and Swenson, clearly utilize notions such as mutual aid and helper therapy in a conception in which people's needs for one another are emphasized. They cite Katz and Bender's (1976, p. 9) definition of self-help group as "voluntary, small group structures for mutual aid and accomplishment of special purpose."

Cited by Lee and Swenson (1986, p. 370) is Levy's descriptive classification of self-help groups with four types of focus: (a) conduct reorganization or self-control, as with addictions; (b) mutual support, to deal with common stress issues; (c) well-being enhancement, for groups whose members are subject to discrimination; and (d) personal growth.

The self-help concept implicitly focuses on (a) insufficient response from "existing institutions" (Katz & Bender, 1976, p. 9); and on (b) gains from shared predicaments; as well as greater readiness (c) to accept one's problem, (d) to want to change and (e) to develop and resume competencies (Katz, 1965) generates an implicit "reevaluation of professional helping." Yet, as Lee and Swenson (1986) note, the foregoing positive assumptions about self-help are the same assumptions made by social group workers about the group work process (1986, p. 370). They (pp. 373-4) adapt Toffler's (1971, 384-5) suggestion for the use of "situational groups" as a key future key social service. Toffler describes these as "temporary organizations...for people who happen to be passing through similar life transitions at the same time." People are thereby helped to cope with a shared, "common adaptive experience" through (a) implicit, mutual identification, and (b) the strengthening of members who come to see their problems more objectively by trading ideas and insights, and suggesting alternatives. The authors, noting that Toffler is referring to the mutual aid group, cite Schwartz's (1959, pp. 114-15) view that the

rise of group work agencies and mutual aid groups provided a needed balance against the forces of industrialization, through the positive effects of group association.

Gitterman (1985/6, pp. 30-2) ties the life model more explicitly to its group work roots in his retrospectively elucidating the central ideas of Schwartz's reciprocal model. The notion of reciprocity was woven into his writing. The "symbiotic" relationship seen between man and his societal needs models the relationship between the individual and his nurturing group, and his formed and natural groups, which serve as the basic medium for individual/social exchange. It is through the practice of the profession that the worker mediates among competing and varied interests and demands which emerge in specific "transactions between individual member needs and group requirements; and between group needs and agency services" (p. 30). "As members invest themselves in the mutual aid system, says Gitterman, they examine their behaviors and perceptions and experiment with responses which are more adaptive. They also achieve a sense of collective strength, a bond through which they usually test the worker's authority. A successful "taking and sharing" of power moves the members of a group to a more intimate level while they unanimously experience increased confidence and mastery over obstacles in their environment. The group may thus become a major force "for organizational and social influence and change."

Gitterman (1985/6, pp. 33-5) reiterates Schwartz's four-phase social work method which was not intended for group work alone. The events in these phases have counterparts in the life model conception. (a) In the *preparatory* "tuning in" phase, the worker prepares for the group experience. (b) In the "*contract*" phase, both worker and members begin together to mutually identify and agree on the conditions of their work, the purpose and role of agency, worker and members are specified in a frame of reference for the work which follows and helps keep the group on track. (c) The *work phase* is the period during which the group purpose is operationalized. (d) In the *termination phase* the worker leaves and the members too may separate. Gitterman (p. 36) summarizes that the force in Schwartz's position is that the symbiotic potential, which at times may exist as a skewed and parasitic reality, "provides the worker with a vision of a reciprocal, relationship, and therefore a clear and visible professional function."

Shulman and Gitterman (1986, pp. 4-9) relate the life model as a perspective to the mutual aid group as a vehicle for work within the model, and the mediating function of the group worker as the means through which the profession's purpose and the worker's function are carried out in such a group. The varied stages of development and intergenerational cogwheeling are described to illustrate a multitude of *life transitions* which generate stresses with which individuals and groups must deal.

Environmental pressures are represented by degree of availability (through organizations, with the help of social networks) of needed resources (goods, services, opportunities) based on economic privilege and other harsh realities. *Maladaptive environmental processes* which generate stress may be generated by such varied sources as group or family composition and structure, environmental expectations and limitations, and developmental transitions.

In the mutual aid group, individuals use one another to create many helping relationships which, as the authors state in citing Schwartz (1961), is a necessary part of the group process and embodies a common need beyond the particular tasks for which the group was formed. Shulman and Gitterman (1986, pp. 9-15) identify nine mutual aid processes in an effective small group. In (a) *sharing data*, members provide for one another what in their respective experiences have been helpful ideas, facts, beliefs and resources. (b) The *dialectical process* "consists of one or more members advancing a thesis, other members countering with an antithesis, and the group members attempting to develop their own synthesis," in efforts to deal with difficult problems. (c) *Discussion of a taboo subject* engages the courage of individual members or may put a person in touch with hidden feelings which may enable the person to present the group with a difficult problem requiring mutual aid. (d) The "*all-in-the-same-boat phenomenon*" is the "healing process which occurs when one

realizes that one is not alone and that others share the problem, the feeling, the doubts, and all the rest." (e) *Mutual support* comes from members and the group as a whole, as empathy and understanding in the face of one's difficulty or trauma.

(f) Support's inverse, and equally vital component is *mutual demand*, which involves confrontation or demand of members upon one another, in a growth process. (g) The group may help a member with a specific problem through *individual problem solving*. (h) *Rehearsal*, which is a form of role play, can help a member to prepare for an action needed toward resolving a problem. Finally, (i) the "*strength-in-numbers phenomenon*" may enable group members to feel safe enough to initiate steps toward problem-resolution. It is only through the skill of the worker and group that the *potential* for mutual aid may actually emerge in the group. Obstacles to be overcome include societal taboos and aspects of the group's culture.

By extension of the general function of social work in society, the social worker as mediator in the group, "mediates the individual/group engagement" (Shulman & Gitterman, 1986, p. 16). As the authors cite in Schwartz's work (1961, p.157, 159-161), a principle task of the mediating function involves the worker's attempts to "search out the common ground between the individual and the group." This may involve the pain inherent in one member's problem, and the pain of the other group members which may cause them to withdraw from that individual (Shulman & Gitterman, 1986, 15-19).

The worker's function in relation to the group process is found in the mediating function. The worker's function in relation to the content of the group's problems, its members' "troubles," is dealt with by the worker's use of knowledge which emanates from the life model as well as from his skill in helping clients with their sources of stress, as manifest in person-environment transactions. Thus, for Shulman and Gitterman (1986), social work's function with reference to environmental concerns focuses on helping the group and its members to utilize organizational and network resources which are available, and to influence those environmental forces toward being responsive. "Mobilizing and strengthening the goodness-of fit between natural and formed groups and their social environments provides social work with a core mediating function. With maladaptive interpersonal processes, the social work function is to help group members to recognize the obstacles and to learn to communicate more openly and directly and attain greater mutuality in their relationships" (p. 19). This involves the worker's examination of members' latent messages, his taking the professional responsibility of following clients' leads, and his joining their natural life processes (p. 20).

On Reciprocity in the Community Context.

Germain (1985, pp. 30-2) conjectures that a general disfavor of biological ideas in the eyes of social scientists may be due to the destructive impact of Social Darwinism, despite early work in human ecology by urban sociologists in the 1920's and 1950's.¹⁰ She sees a similar rejection in community organization which reflects social science influences. Where *community* is the environment of individuals and primary groups, it is integral to them, and is a force to be understood and worked with by the ecologically-oriented social worker. She sees the life model's integrated practice method as lending itself to practice at all levels of human organization, including community.

Germain (1985, p. 32) sees a community not only as (a) the environment of its component individuals, families and groups; but as (b) the client itself. Interventions made on behalf of the community as an entity serve members' well-being.

In discussing transactional outcomes, Germain (1985, pp. 39-40) cites Hawley's (1950) idea of *communal adaptation*: While processes of adaptation and *adaptedness* exist in individuals, in ecology they refer to communally organized units (or species), as they achieve fit with the environment over evolutionary time. The ecologically-oriented social worker's unit of attention must include a community's transactions with its larger physical and social worlds, and with its physical settings, culture, social structure.

Germain (1985, pp. 40-2) conceptualizes the transactional processes of *stress* and *coping* at a community level as the

collective outcome of the shared stress and coping experiences of a proportionately large number of individual community members.

Some *habitats*, based on location and structure, minimize needed available time; or their physical settings of dwellings, buildings, villages, and urban layouts spatial arrangements may not support the social settings needed for family, social, work, and religious life, in a fashion which fits with age, gender, culture and life styles. Such habitats are not supportive of health and social functioning for individuals and families. They may produce or contribute to stressful isolation, disorientation, and despair.

In addressing intervention issues, Germain (1985, pp. 41-2) notes how vital it is that practioners have *knowledge and skill* to approach the work in new ways toward *habitat mprovement*. These ways might include controlling shared habitat conditions; replacing lost networks; and developing mutual aid systems to exchange resources and information, and to reciprocally meet people's needs. She describes Glaser's 1972 work with public housing tenants in stairwell collectives as having positive consequences for family, individual, and group life. The work may begin at any system level, from the collective level of all families who meet on a stairwell, to the family or individual. Habitat improvement may require community level *advocacy* to mobilize group efforts to influence public policy on housing design and location, transportation needs, use of school facilities as community centers, and day care for children and disabled and older adults, as well as workplace issues on time, safety and family-life matters.

Germain (1985, pp. 42-4) recognizes that habitat evokes spatial and temporal behaviors to create a social environment. Stress may be aroused in community members "when there are violations of biologically based spatial needs and temporal rhythms, cultural orientations to space and time, or psychologically based need for, or experience of, space and time exerted by the spatial arrangements of the community's institutions" (p. 43). An example would be the space and time arrangements of a community's health care resources and their fit with the time and space orientations of residents whose work hours, values and norms, differ from those of "outside" providers (p. 43). While the conditions pertaining to space and time which generate stress within the habitat are essentially experienced by individuals and primary groups, interventions may be called for at the community level. Community-oriented programs must operate in the interest of individuals and families, the development of the community itself, and the quality of urban and rural life.

In the ecological metaphor, *niche* refers to the status which an individual or group occupies in a social structure, notably in relation to issues of power and oppression. The health-promoting, growth-supporting elements of a human niche differ with society and historical time. Germain (1985, p. 45) cites DeLone (1979) to note that in *our* society, it is generally assumed that niche is shaped by one's set of rights, including a right to equal opportunity. Millions occupy niches that do not support human needs and goals, as a result of "political and economic structures,

systems of education, health and mental health care, child welfare, juvenile justice, welfare, work and media." This suggests the centrality to social work of efforts to influence all levels of government policy. An ecologically-oriented social worker at the community level must deal with community empowerment, support for community strengths and the reshaping of "nonsalutary niches," to the extent allowed by knowledge and skills.

As per Cottrell (1976, p. 197), Germain (1985) links a set of four ecologically-based adaptive outcomes of people to community outcomes for community social work:

1. The competent parts of a *competent community* (a) are effective collaborators in the identification of problems and needs, (b) achieve consensus on goals and priorities, (c) agree on ways to implement goals, and (d) collaborate on needed actions. A competent community can manage collective life problems, because its members possess skills in discussion, problem-solving, conflict-management and resource location--skills to be modeled and taught by the community-oriented social worker (Germain, 1985, pp. 45-6).

2. A *self-directed community* is concerned with achievement and maintenance of inner strength in systems of mutual-aid and natural support. A practitioner's ability to enable a community to control its destiny by helping people to rediscover their capacities and collective resources, embodies empowerment, to prevent internal disorganization or external tyranny (Germain, 1985, p. 47).

3. A *community's identity* bears on where its boundary is drawn and on which groups are included and excluded, with their

respective and varied life styles, values and norms. The social worker's focus of helping diverse groups to develop reciprocity and mutuality through active involvement in meaningful and 'real' activities, contributes to a community's identity and pride in a context of self-directed competence (Germain, 1985, p. 48).

4. *Human relatedness*, as an ecologically-focused adaptive outcome for people, rests on a "sense of belonging" and "is the essence of community." "Relatedness to others and to the physical setting evokes the reciprocity of caring and being cared about" (Germain, 1985, p. 48) This includes use of natural networks and shared affiliations to transcend harsh conditions and maintain communication channels between disparate groups. "A community laced with natural support systems," whose location, support and encouragement is a social work function, is more likely to be self-directing and competent, with a solid sense of identity (p. 50).

To Germain (1985, pp. 49-50) the ecological view suggests community-level points of entry for primary prevention in programs which promote health and adaptive functioning among community members and prevent negative outcomes for those at-risk.

Programs may focus on (a) *life transitions*, including developmental stages such as puberty, status changes such as retirement, role-conflicts for working mothers, or crises. Programs focused on (b) *interpersonal processes* in collective life might be directed to families, groups, social networks. Those which bear on (c) *environmental issues* might focus on environmental improvements.

Toward Integrating the Dual Focus: On the Person-Environment Fit

Germain (1981, p. 323) sets an agenda for further development of the ecological approach. Social work, to fulfill its potential "in the postindustrial, prefigurative society of the 1980's," will require expanded "knowledge about environments and people-environment relations." The environment's being conceptualized less carefully than the psychological realm, coincides with some practitioners' preference for knowledge and skill in individual, family and group interventions, which are seen as "direct" and more vital than "indirect" environmental work. For Germain, "social provision, concrete services and environmental manipulation (as in foster care) are exceedingly complex [sic]." They entail creating a match between peoples' needs and goals and their environments "by [a] selecting among environmental options, [b] creating environmental instruments of help, and [c] intervening in people-environment transactions in order to release adaptive capacities and improve environments."

Germain (1981, p. 331) notes the utility of conceptualizing environmental complexity, toward the development of "practice principles, skills and techniques for work in environments." She notes how little is known about what is a nutritive environment, in light of the variability in peoples' needs, capacities and aspirations, and little knowledge about reversing the "effects of noxious environments." She calls for research focused on "the transactional nature of adaptation, stress, and coping."

The concept of *person-environment fit* is treated by Coulton (1979, pp. 159-60, 171-2; 1981, pp. 26-7), in health care and health care research, as a multidimensional concept, based on the degree of congruence between a person's needs, capacities, and aspirations and the resources, demands and opportunities of his environment. Such fit may vary in a lifetime from maximum congruence, to severe discrepancy when conditions include discrimination, limited environmental resources and opportunities, or limited individual capacities. Optimal fit, with facilitated performance, is conceived when one's capacities and aspirations are consistent with environmental demands and opportunities, and when one's needs can be met by available environmental resources. A persisting lack of fit, or discrepancy, contributes to dissatisfaction, distress, frustration, illness or psychological disturbance. Interventions may optimize fit by changing characteristics of person, environment, or both.

Coulton (1981, pp. 27-34) presents a set of research-developed dimensions of person-environment fit. These comprise (a) *physical dimensions*, and (b) *psychosocial dimensions*, which include role performance and role expectations, interpersonal relationships, cognitive capacities in the form of knowledge and understanding of experience, capacity to regain order and control, and capacity to engage in activities. Other dimensions are (c) the extent of one's *repertoire of behaviors* and (d) one's capacity to engage necessary *economic resources*. She also developed a typology of interventions for health care, conceptualized according

to target and goal, to guide the social worker in deciding on whether to emphasize person, environment or both in interventions.

Weick (1981, pp. 140-1) proposes concepts intended to reinstate the person-in-environment paradigm in a way that allows for a person to be seen as acting "in the broadest possible environment. For Weick, the concept of environment is strengthened if it is seen as a multidimensional field of both internal and external factors. She explores four possible environments which shape behavior.

The (a) *internal-social environment* contains "personal history, intrapsychic processes, emotions, thoughts, aspirations and beliefs, all of which contribute to the individual's behavioral style and characteristic responses." The (b) *external-social environment* holds influences of "culture, social structure, technology, and economic and political arrangements." Together these have formed "the basis of the person-in-environment paradigm." It has enhanced our interactive understanding of behavior in social environments to the exclusion of the physical (Weick, 1981, p. 141). Extension of the environment concept to the realm of (c) *internal-physical* and (d) *external-physical environments* challenges the distortion of the mind-body dichotomy. It calls on social work to include physical, genetic, metabolic, organic functioning of the person together with environmental conditions which pose a threat to the challenges and limitations of our adaptive capacities. For Weick the four environmentally conceived influences provide a broader diagnostic base (p. 141-2).

Health, in this view, is defined "as a qualitative expression of the interaction among environments." "Good health represents a state of positive interaction among the various spheres, while ill-health is its disruption." Weick proposes an intervention approach which is health-based as opposed to pathology-based and which is synchronous with the life model: A client is seen as having the ability to heal himself. A worker may help the client, who is seen as a subject rather than an object, to mobilize his own healing forces. The premise is that people are endowed with two vital capacities: "the power to see things clearly and the power to change." This "radical" view "puts individuals directly in touch with the power to affect their lives" (Weick, 1981, p. 142).

Germain (1983) in recounting emerging theory about people-environment transactions, speaks of heredity and environment as complementary with intelligence and culture, "transcending biological, psychological, and environmental limits" (p. 112). Referring to Dobzhansky, she voices the assumption that all personal characteristics have a genetic potentiality, but their actual occurrence in an individual depends on environmental experience. Some characteristics, for which she cites Hartman's sphere of primary autonomy, are less environmentally dependent for expression than others, such as those which pertain to the sphere of secondary autonomy. "But," she goes on, "all represent a mixture of genetic endowment and environment experience, supplemented by some freedom to select environments by which to

be influenced" (p. 113). Drawing on Dubos, (1968) she comments on the adaptive demands beyond psychological and biological limits, which are placed on humans by self-created, urbanized, technological environments. Given the evolved plasticity of humans, nonsalutary environments can be tolerated more than is good for the quality of life. "Physiological and behavioral responses may maintain an intimate adaptive balance but may result in degenerative and chronic physical disease or emotional disorders later," as with an undernourished child who adapts with restricted activity, but pays a lifetime price in abnormal brain development (Germain, 1983, 113).

Germain (1983, pp. 114-15) remarks on how little is known about nutritive environmental qualities, and how much is assumed based on cultural idiosyncrasy and values. Examples of such erroneous assumptions are that babies can form only one primary attachment, such as to mother, with the exclusion of father or others; or that "slum neighborhoods" with openly poor physical plants and less visible rich social networks are disorganized. More research on issues such as person-environment fit (Coulton, 1981) or the fit in agency-client arrangements (Maluccio, 1979a) is seen as needed.

In dealing with person-environment transactions, Germain (1983) sees the social worker as trying to change feedback loops at the level of person, family or group, to "interrupt negative feedback processes that prevent needed change in behavioral systems or positive feedback processes that escalate change beyond

the system's limits" (p. 115). Furthermore, interventions may occur in varied forms, in different parts of a system, as in the case of depression, where interventions might be geared to interrupt feedback processes "that sustain and intensify the problem" between the person and family member, network, or organization such as workplace, school, or agency (pp. 115-16).

Coping responses serve as feedback processes, to reveal how the organism is doing. Stressful experience elicits coping responses of a physiological (adrenalin releasing), cognitive (problem solving), or behavioral (information seeking) nature. Effective coping may reduce or eliminate stress. If stress is intensified or not released, results may include physical illness, emotional disturbance or social disruption with more stress ensuing. Germain elaborates on how maintenance of sufficient internal comfort and self-esteem is needed to allow for effective coping and problem solving. Such a state requires internal resources, social supports, information, time for strategy development and action, and effective cultural solutions. Our professional responsibility falls in the spheres of (a) reducing or changing environmental demand, through environmental instruments or advocacy; (b) perception of that demand through reappraisal with the client system; and (c) supporting and mobilizing more effective client coping responses (Germain, 1983, pp. 116-18).

Complex *organizations*, says Germain (1983, p. 122), are among environmental forms which humans create to solve complex

problems and achieve particular goals in various areas of life. Social workers may help their agencies' bureaucracies to function responsively to client needs and to professional imperatives, by calling on organizational theory. Organizational properties vital to change efforts by social workers are *centralization*, *formalization* and *stratification*, which are manifest in an agency's formal and informal systems.

Centralization reflects distribution of power through authority in the formal system, and via influence in the informal one. *Formalization* refers to rules which contribute to the maintenance of efficiency, impartiality, and fairness." Informal rules may be found in norms and traditions, and may render service more effective. Rules may also be rigid regulations which subvert goals by serving organizational needs to the exclusion of client needs. *Stratification* reflects agency reward distribution. Status and prestige, for example, may call forth greater income and larger work space, and can interfere with change efforts which threaten staff self-interest (Germain, 1983, pp. 122-3).

An *organizational analysis* or assessment provides the wherewithall to determine feasibility of the goal of change, and a plan of strategies through which to achieve it. Once a plan is settled on, its implementation is achieved through change efforts with a range of skills such as "program demonstration, joint problem-solving, persuasion, negotiation, and bargaining" (Germain, 1983, p. 123).

Parallel Developments

On Ecological Competence and Assessment.

For psychologists Sundberg, Snowdon and Reynolds (1978, p. 180), assessment aims to discern individual characteristics of importance to decisions in person-society relationships. They define competence as connoting "a search for positive characteristics, particularly capabilities for coping with life situations." They cite Bloom's (1977, 250) statement about competence in relation to community mental health, that among concepts which "link individual problems to characteristics of the social system, the most compelling have been the concepts of competence and competence building."

As psychologists with roots in a tradition of measurement, Sundberg et al. (1978, p. 203) state that "if assessment of competence is to succeed, it must avoid the pitfalls of excessive individualism which characterizes much of the history of assessment of intelligence." They call for "as much attention to assessment of the environment or situation as to the individual." They point to the medical model as tending to 'blame the victim' and to some radical therapists as tending to blame only the environment. They cite three major environmental dimensions identified by Moos and his colleagues: relationship, personal development, and system maintenance and change.

Sundberg et al. (1978, 196, p. 207-8) propose a conceptualization of *assessment of ecological competence* to account for complex person- environment interactions. The notion would (a) avoid old labels which arise from intelligence measurement and psychopathology; (b) account for the multipotentialities of clients; (c) consider diverse cultural contexts; (d) not utilize normative judgments to reject clients; and (e) assess current as well as potential environment when assessing a person. They propose that the notion of adaptation requires assessment of both the motives of the individual and the demands and resources of the environment. Competence implies an ecological situation in which individuals actively move through settings which provide "nutrients" or supports for certain kinds of self-expression and coping, but not for others. Thus, competence in functioning and coping relates to the particulars of the environment in which they occur. They recommend the expansion of community programs which focus on "life changes, life-long learning, and general enhancement of coping skills and quality of life" (p. 208). They recommend a future combining of personal (micro) assessment with program (macro) assessment.

Some Further Notes on Competence.

Maluccio (1979b), having previously addressed the growth potential of action in life events, promotes the therapeutic potential of life experiences in the actual life contexts in which they occur. He cites theorists from varied disciplines around the

definition of competence. He refers to White's view (previously cited) of competence in relation to the ego. He notes the knowledge and skills needed by the individual in Gladwin's view (previously cited). He summarizes Foote and Cottrell's (1955, pp. 45-60) definition of competence as "the ability to perform certain kinds of tasks and to control the outcomes of episodes of interaction." He sees Smith's social psychological view as influenced by three sets of mutually corresponding factors (a) in the personal system, *hope, self-respect, a sense of efficacy in controlling one's destiny*; and (b) in the social structure *opportunity, respect by others, power*. Maluccio (pp. 285-6) sums up these varied formulations with G. Allport's (1961) view that competence (as borrowed from White) is not merely a need, but a life motive unto itself, through which we survive, grow and become "self-actualizing."

Maluccio (1979b) sees a twofold use for the concept of competence in social work practice: to restructure environments, and to propel adaptive processes in client systems (p. 286). Toward these ends, life as the arena of change is where experiences, events and processes may be used for their therapeutic value as an avenue of effective help through action. A client's situation then becomes the focus of opportunity for the use of striving, coping, and goal-directed action" (p. 289). It is in the *life-space interview*, developed in residential work with disturbed children by Redl (1959), that clinical and growth-producing exploitation of life events can occur. It is organized

around the child's life experience in relation to issues which become the focus of the interview by a person whom the child sees as part of his natural environment or "life space" (pp. 293-5).

Environmental restructuring as a principal means of helping, may be used as a force through which to promote "people's efforts toward competence and adaptation," notes Maluccio (1979b, p. 296). In this spirit a vital worker function is to help the client to seek, modify or create opportunities. This occurs in "milieu therapy" as well.

Maluccio (1981) further integrates the notion of competence with an ecological approach "by providing guidelines and action principles for social workers engaged in work with individuals, families or groups," based on facilitating natural adaptive processes and promoting competence in clients' interaction with their environment (p. 2). He defines four approaches to conceptualizing competence.

1. The *achievement approach* equates competence with achievements through one's own efforts (Maluccio, 1981, p. 3).
2. In the *internal antecedents approach*, motives, personality traits and cognitive skills set the stage for competence. He includes White's formulation here, which for all its richness, does not really describe what is included in competent behavior, nor how to go about facilitating it (Maluccio, 1981, pp. 3-5).
3. The *behavior-environment interactions approach*, which includes Inkeles' and Gladwin's formulations, emphasizes societal

as opposed to psychological referents such as social requirements and role performance. It also includes Smith's views which integrate behavior and environment by linking the personal system and the social structure. For Maluccio, these views enhance White's formulations, especially because they add the essential factor of social feedback or social reinforcement to White's notion that a person's actions are simply intrinsically rewarding and motivating (Maluccio, 1981, pp. 5-6).

4. In the *ecological approach*, Maluccio (1981, p. 7) refers to the conceptualization of ecological competence of Sundberg et al. (1978). Maluccio notes that "in traditional formulations, competence is generally considered a property or trait of the person." In contrast, in the ecological approach, competence becomes a transactional concept, an attribute of the *transaction* between person and environment. Such a notion of competence which is not a direct attribute of a person, is difficult to conceptualize. He nevertheless elucidates the components of ecological competence, which he believes "can sensitize us to the importance of what is happening between people," their "needs, qualities, and coping patterns and...the properties of their impinging environment."

Maluccio (1981, pp. 7, 9) illustrates the interplay between the three major components of ecological competence and some of their suggested constituent aspects. He notes that specific constituents apply in specific circumstances and vary with culture. Thus, "it is useful to think in terms of *general* capacities or

qualities that are universally required (such as the capacity to gather and use information) and *particular* capacities or qualities that are needed in specific contexts (such as certain skills required in industrial societies)."

The first component consists of a person's (a) *capacities and skills*. These cover diverse realms such as "cognition, perception, intelligence, language, and physical health;" and qualities such as flexibility, tolerance for diversity and anxiety, reality testing and judgment; and diverse proficiencies which might include athletics, as well as interpersonal and emotional skills (Maluccio, 1981, pp. 7-8). As Mechanic notes (1974, p. 33) this also depends on the efficacy of solutions which one's culture provides, and the adequacy of a society's preparatory institutions to reach these solutions and the accompanying skills. The second component, an individual's (b) *motivational aspects*, includes interests, hopes and aspirations which would comprise his "effectance," or "competence motivation" as described by White. The third component, (c) *environmental qualities*--such as resources, supports, demands and institutional pressures--impinge on an individual's functioning at a particular time. "Effective behavior requires 'goodness of fit' with complementarity, between environmental demands and supports" (p. 8). In a citation of Mechanic (1974, p. 33), Maluccio emphasizes that "the ability of persons to maintain psychological comfort will depend not only on their intrapsychic resources, but also--and perhaps, most

importantly--on the social supports available or absent in the community" (p. 8).

Maluccio (1981, p. 12) strikingly ties competence-oriented practice to the life model by citing eight themes which are common to both. These include (a) the *humanistic* perspective; (b) the definition of problems in *transactional* terms; (c) assessment which includes *competence clarification* for the client system, the environment and their fit; (d) role emphasis for clients as *resource* (rather than carriers of pathology), and for workers as *enabling agents*; (e) the client-worker relationship defined especially in terms of *mutuality* and *authenticity*; (f) *life processes and experiences* (including creativity) as the main focus; (g) *use of environment* emphasized; and (h) *client feedback* utilized regularly.

As Maluccio (1981, pp.22-3) sees it, "competence-oriented social work practice can play an essential *triggering function*: It can serve to set in motion or mobilize the client's coping capacities, natural life processes, and strivings toward growth." He cites his own study (1979b) of client perceptions of service as evidence of the value of the triggering function in competence-oriented, life process interventions. Clients, in verbal reports, provided a subjective sense of their workers' effectiveness as enablers, and of their consequent experience of more effective coping and environmental mastery, which Maluccio sees as enhancing dormant abilities as well as new patterns of coping.

On Social Work Assessment and the Naturalist Paradigm.

For Rodwell (1987), the normative, scientific goal of locating one truth via professional objectivity (p. 235) is "unattainable and destructive," because to favor the existence of a single reality inhibits the best in our practice, which is "understanding the unique experience of the individual in context" (p. 237). Rodwell (p. 237) applies the five (previously noted) axioms of the naturalist paradigm (Lincoln and Guba, 1980), to seven guidelines for research, and by extension for assessment: (a) Inquiry should be conducted in the context of what is being studied. (b) Humans are the most adaptable and adjustable data-gathering instruments. (c) Tacit (intuitive) knowledge is of equal value to propositional (linguistically expressed) knowledge, notably for appreciation of the shades of different realities. (d) Qualitative methods which reflect normal human activities are favored over quantitative ones as they can be better adapted to dealing with varied realities. They expose the nature of the investigator-respodnent transaction more directly (p. 240). (e) Meanings and interpretations which are negotiated with their human sources are preferred because it is these human constructions of reality which the inquirer seeks. (f) Idiographic (case by case) interpretations are preferred over generalizations, because different interpretations may have meaning for different realities, with less emphasis given to notions of "typical" cases. (g) Tentativeness must guide any genera;lized application of findings because realities vary (Rodwell pp. 239-40).

Rodwell (1987, pp. 240-2) (using child abuse as an example) presents the following propositions about social work assessment:

- (a) "The nature of the problem would be seen as an interactive, situational one."
- (b) The purpose of assessment would be determination of the factors in that must be overcome in the (abusive) situation, if a future problem is to be prevented.
- (c) Focus would involve "all important stakeholders" (in the batterer's family, for example).
- (d) No prior assumptions would be made about the problem's boundaries or who is involved in its definition.
- (e) The social worker's posture would be investigative.
- (f) Provisional reports would be open to corrective scrutiny of all informants, so as to capture accurately the multiple perspectives.
- (g) A final assessment would be completed only when work with the entire family had concluded, because the work itself would be adding revised meaning to the situation.
- (h) The assessment report would be far more narratively descriptive than objective and conclusive in nature, and
- (i) would reflect the multiple realities of the participants.

For Rodwell (1987, p. 243), naturalistic inquiry is seen as congruent with social work values. It provides a different construction of expectations for the profession, namely that

- (a) there are multiple viewpoints,
- (b) the individual is unique in her own context, and
- (c) "the social worker has no responsibility to produce a 'particular' outcome."

The preceding historical-theoretical literature review has been presented in two sections: (a) material which appeared up to the late 1970's (Chapter II), and (b) material which has appeared since that time.

Chapter II presents the relevant conceptual elements of the linear-mechanistic approach of the clinical-normative model in casework as it has expanded in an increasingly holistic and organismic direction through efforts of its adherents to respond to a more complex world. As these changes progressed, a shift to an ecologically-anchored world-view began to emerge in the contributions of practitioners who saw the old view as being insufficient to deal with the complexities of people, their needs, problems and relationships in a rapidly changing post-figurative world. Chapter III, which begins with contributions since this study was conceived in the late 1970's, presents elaborations of the ecological-systems approach and its life model application to practice.

The material contained in Chapter II presents basic conceptions that have been organized into principles which underlie the two alternative approaches on which this research focuses. These underlying principles and related operationalized criteria for practice are presented in Chapter IV, in the next several pages, along with this study's variables and hypotheses.

CHAPTER IV

Definitions and Hypotheses

Introductory Note

This study was designed (a) to determine discernible differences in what social work student clinicians say they believe about their practice orientations; and (b) to determine correlations between these beliefs and what social work student clinicians say they would do in specific kinds of simulated practice situations.

The literature was reviewed to trace the historical and theoretical development of the two approaches which are under study. As the linear-mechanistic approach began to change in an effort to accommodate itself to a more complex world, the precursors of the ecological-systems approach began to develop, and that approach began to coalesce.

Defining the Variables

By drawing on the conceptual-historical review of the literature, definitions of the study's principal independent variable (IV), its two dependent variables (DV's), and its two secondary IV's will be presented in five sections which allow us to operationalize the hypotheses which then follow.

1. Clinical-Orientation (Linear-Mechanistic versus Ecological-Systems): Principal Independent Variable.

Conceptual definition. Clinical-orientation may be conceptualized as the social worker's view, organization and interpretation of the knowledge base which underlies person-environment/person-situation concepts (see Bartlett, 1970, pp. 51-66, 62-83).

Operational definition. For this study, clinical-orientation is defined through the identification of the degree of a clinician's self-perceived adherence to specific theoretical-conceptual alternative views of practice, conceptualized in a series of eight (later revised to six) principles which present sets of linear-mechanistic and ecological systems alternative views of practice. The differences involve *distinctions between* (a) linear-causality versus equipotentiality; (b) analytic versus organismic qualities; (c) drive-reduction toward a static equilibrium as opposed to the active readjustment of a steady-state; (d) adherence to mind-body dualism versus its rejection; (e) emphasis on regressive as opposed to progressive forces; (f) intervention in isolation versus in the client's life context; (g) rejection of teleology versus acceptance of purposeful phenomena; and (h) the application of linear causality as opposed to living systems principles.

Figure 1, which follows, illustrates these differences.

Figure 1. Comparative outline of principles which underlie the linear-mechanistic and ecological-systems approach.

<u>Linear-mechanistic approach</u>	<u>Ecological-systems approach</u>
1. Linear causality.	1. Equifinality.
3. Additive analytic quality. An entity may be understood by reduction to the sum of its parts, and their separate analysis.	3. Organismic quality. The whole is equal to the sum of its parts, plus the relationship among parts.
4. Homeostasis model. Drive reduction to static equilibrium.	4. Heterostasis model. Active readjustment in steady - state.
5. Adhere to mind - body dualism.	5. Rejection of mind-body dualism.
6. Entropy. Emphasis on regressive forces which inhibit growth.	6. Negentropy. Emphasis on progressive forces which promote growth.
8. Client-worker encounter isolated from the life-context the person, family or group to be helped.	8. Client-worker encounter within the life-context of the person, family or group to be helped.
*2. Rejection of teleology, with explanation of environmental and psychic determinism. Past directed.	*2. Ordered, purposeful spontaneous phenomena and behavior to maintain the organism. Present- and future-directed.
*7. Application of linear-mechanistic principles from 19th century science to behavioral, psychological and social phenomena.	*7. Application of living systems principles from organismic biology to behavioral, psychological and social phenomena.

*Although principles 2 and 7 (in lighter print) were initially utilized, they were subsequently eliminated in their application to the development of their respective scales on Instrument-1, based on internal reliability testing of Instrument-1.

2. Assessment: Dependent Variable.

Conceptual definition. Assessment may be thought of as a process in which a common base of professional knowledge is selectively and competently applied in professional judgments toward understanding and identifying characteristics of people with problems in their psychosocial situations (see Bartlett, 1970, pp. 139-170).

Operational definition. For this study, assessment consists of judgements in five areas from which to view and understand a client's psychosocial situation. Each area is represented by two alternative judgment choices of aspects of the two practice approaches being studied. Assessment-related differences emerge from the same alternate orientations to the world as do the theoretical distinctions of clinical-orientation. These assessment distinctions are, however, specific, close-to-the-work criteria which operationally define aspects of assessment. The *five assessment criteria* involve *distinctions between* (a) unilateral versus mutual assessment; (b) focus on personality deficits as opposed to strengths; (c) acceptance of environmental stability with deficits, versus search for environmental change and supports; (d) coping seen as a function of personality structure as opposed to person-environment mesh; (e) understanding based on history as opposed to current factors.

The operationalized criteria for assessment are set forth in Figure 2 which follows.

Figure 2. Comparative operationalized criteria for assessment.

Emphasis on linear-mechan.

1. Unilateral assessment by clinician to define problem/situation.
2. Focus on personality deficits (ego's defensive capacities) as limitations to growth and change.
3. Acceptance of environmental stability with deficits.
4. Coping as a function of change through personality structure or internal conflict resolution.
5. Focus on history to understand the problem in the present.

Emphasis on ecolog.-systems

1. Mutuality by contracting to define problem/situation.
2. Focus on personality strengths (ego's defensive capacities) as enhancements to growth and change.
3. Search for environmental change and supports.
4. Coping as a function of mesh, transactions between person and environment.
5. Focus on current factors to understand the problem in the present.

3. Intervention Plans: Dependent Variable.

Conceptual definition. Intervention planning, based on psychosocial assessment, may be thought of as a process in which the clinician defines what kind of change is needed and what can be done professionally to influence movement toward that change (Bartlett, 1970, pp. 153, 161-162).

Operational definition. For this study, intervention planning consists of action plans in nine areas of the change process in which the two approaches differ. Each area is represented by alternate judgment choices of aspects of the two practice approaches being studied. Intervention-related differences come from the same alternate orientations to the world as do theoretical distinctions of clinical-orientation. The distinctions are, however, specific, close-to-the-work criteria which operationally define specific aspects of intervention planning. The *nine intervention plan* criteria involve *distinctions between* (a) unilateral clinician prescriptiveness versus mutual clinician-client decision-making; (b) abstract, general versus concrete, specific goals; (c) focus on the limiting quality of personality deficits as opposed to engageable, adaptive quality of personality strengths; (d) limited versus maximal focus on use of environmental supports; (e) use of office versus life context for interventions; (f) client versus environment as point of entry into case; (g) use of verbal dialogue as opposed to tasks as intervention method; (h) clinician's role as therapist versus broad range of roles; (i) client resistance as opposed to transactional difficulties to explain lack of change.

Figure 3. Comparative operationalized criteria for intervention plans.

<u>Emphasis on linear-mechan.</u>	<u>Emphasis on ecolog.-systems</u>
1. Unilat. prescriptiveness by clinician as expert to decide on interven. plan.	1. Mutuality via contracting between clinician & clt., to decide on interv.
2. Abstract, general conceptual goals.	2. Concrete, specific next steps for change.
3. Personality deficits (ego defenses, growth-limitations) as limitations to intervention.	3. Adaptive personality strength (ego coping behaviors and capacities) as engageable in intervention.
4. Environmental supports seen as limited in availability and helpfulness, with minimal focus toward meeting client need.	4. Environmental supports seen as vital in meeting client need, to be located or established whenever possible.
5. Interv. in agency/office, not to intrude in clt's life.	5. Intervention in context of client's daily life.
6. Client(s) as the "point of entry" for interv. plans.	6. Use of aspects of clt's envir. as "pnts of entry."
7. Client-clinician verbal dialogue toward increased emotional expression, self-understanding, insight by client.	7. (Graded) tasks/steps for clt. use of inner & envir. resources to experience new coping skills with human & physical envir.
8. Clinician as primary helper or therapist through verbal dialogue.	8. Clinician broad roles e.g., enabler, broker &/or advocate in interventions.
9. Client resistance to explain lack of change.	9. Transactional difficulties between clt. & envir. to explain lack of change.

In addition, practice may be said to have meaning in a human context. We may conceptualize various contextual factors which traditionally have meaning in social work practice. Two sets of such contextual factors have been utilized as secondary independent variables in this study. One contextual variable is *duration-severity*. A second contextual variable is *interpersonal-context*.

The thinking behind the choice of these two (secondary) IV's is as follows: First, it was deemed to be of value to see how our the primary IV, clinical-orientation, would perform under varied and "extreme" conditions. The idea was to pick specific conditions which theoretically might pull the results in one direction or another. The conditions would be standard and important aspects of day-to-day clinical social work. The conditions would be meaningful to the purposes of this study. Finally, it could enhance social work knowledge to test conditions that are relevant to problem/situations which are regularly encountered in practice.

4. Duration-Severity: Secondary Independent Variable.

Conceptual definition. Conceptually, this variable combines two factors: *duration* of a client's psychosocial impairment, which is a temporal concept, and *severity*, a quantitative concept which refers to the relative degree of that client's psychosocial impairment.

Operational definition. Operationally, the combination of factors may be represented on a continuum between two end-points: *chronic* and *acute*. This secondary independent variable combines two factors which may be thought of as linked from a clinical perspective. Chronic duration-severity represents long duration coupled with strong severity of problem/situation. It generally portends serious developmental, diagnostic and treatment issues. Its implicit emphasis on psychosocial dysfunction and psychopathology, as well as history (over time), might make it easy for linear-mechanistically-oriented clinicians to tune into. Such a condition might be more amenable to a linear-mechanistic pull than to an ecological-systems pull. *Acute* duration-severity, on the other hand, may be thought of diagnostically as an adjustment disorder or situational disturbance, which represents an immediate, short-term interplay of psychosocial factors, and may therefore be seen as far more amenable to an ecological systems interpretation, and easy for ecological-systems oriented clinicians to tune into.

The idea of linking duration and severity of problem/situation into one factor, called *duration-severity*, was an effort to maximize variance by linking two powerfully differentiating factors, which may be seen as frequently going together in situations of serious psychopathology. The factor duration-severity was conceptualized in a simplistic way for purposes of this study, to reflect either an *acute*, mild, reactive problem/situation, or a *chronic*, longstanding, seriously pathological problem/situation.

5. Interpersonal-Context: Secondary Independent Variable.

Conceptual definition. This variable refers to a general degree of interpersonal involvement (or lack of involvement) with other human beings.

Operational definition. This factor may be represented on a continuum which reflects either an interpersonally *isolated* or an interpersonally *involved* presenting problem/situation for a client. It was conjectured that someone who is rather involved with other human beings, or at least has the opportunity for such involvement, would present a problem/situation which lends itself easily to being conceptualized from a systems viewpoint, given the opportunity available to a clinician to conceptualize several humans in relationship to one another more easily in a system than one isolated person. It was thought that the involved situation might tend to generate an ecological-systems pull on assessments and intervention plans.

By the same token, an isolated client might be seen as presenting a problem situation in which the relationship between client and social environment would be more difficult for a clinician to see and conceptualize. Focus on the client alone might present fewer problems for assessments and intervention plans for a linear-oriented clinician than for an ecologically-oriented clinician. Thus, an isolated client's problem/situation might tend to generate a linear-mechanistic pull on assessments and intervention plans.

Hypotheses

1. Clinical-orientation as Related to (a) Assessment and (b) Intervention Plans.

Hypothesis-1a.

General: There is a positive correlation between measures which reflect what particular clinicians say they believe about their clinical-orientation, and measures of the kinds of assessments which they would formulate in specific practice situations.

Specific: Clinicians who reflect a linear-mechanistic perspective will tend to formulate assessments which emphasize linear-mechanistic criteria, such as "unilateral assessments" and "emphasis on history." Clinicians who reflect an ecological-systems perspective, will tend to formulate assessments which emphasize ecological-systems criteria, such as "mutuality through contracting" and "emphasis on current factors." (Figure 2 lists all criteria.)

Hypothesis-1b.

General: There is a positive correlation between measures which reflect what particular clinicians say they believe about their clinical-orientation, and measures of the kinds of intervention plans which they would formulate in specific practice situations.

Specific: Clinicians who reflect a linear-mechanistic perspective will tend to formulate intervention plans which emphasize linear-mechanistic criteria, such as "personality

deficits" and "clinician as therapist". Clinicians who reflect an ecological-systems perspective, will tend to formulate intervention plans which emphasize ecological-systems criteria such as "personality strengths" and "varied clinician roles". (Figure 3 lists all criteria.)

The reader will note that there are two main instruments. Instrument-1 determines each subject's clinical-orientation. Instrument-2 contains four case vignettes, which are each followed by a questionnaire. Along with providing data for measures of the kinds of assessments and intervention plans determined by each clinician, Instrument-2 also provides measures of the effect of context on assessments and intervention plans. There is a hypothesis with reference to each contextual (secondary independent) variable, for both assessment and for intervention plans.

The first contextual variable is *duration-severity*. Its hypotheses follow.

2. Duration-Severity as Related to (a) Assessment and (b) Intervention Plans.

Hypothesis-2a.

General: There is a positive correlation between measures of duration-severity of problem/situation, and measures of the kinds of assessments formulated by participating clinicians in specific practice situations.

Specific: A client who is depicted as *chronic* should induce more linear-mechanistic assessment judgments by clinicians, an example of which would be "unilateral assessment" (as shown in figure 2). A client who is depicted as *acute* should induce more ecological-systems assessment judgments by clinicians, an example of which would be "mutuality by contracting" (as in figure 2).

Hypothesis-2b.

General: There is a positive correlation between measures of durationseverity of problem/situation, and measures of the kinds of intervention plans formulated by participating clinicians in specific practice situations.

Specific: A client who is depicted as *chronic* should induce more linear-mechanistic intervention judgments by clinicians, an example of which would be "personality deficits" (as shown in figure 3). A client who is depicted as *acute* should induce more ecological-systems intervention judgments by clinicians, an example of which would be "personality strengths" (as seen in figure 3).

The second contextual variable is *interpersonal-context*. Its hypotheses follow:

3. Interpersonal-Context as Related to (a) Assessment and (b) Intervention Plans.

Hypothesis-3a.

General: There is a positive correlation between measures of interpersonal-context of problem/situation, and measures of the kinds of assessments formulated by participating clinicians in specific practice situations.

Specific: More specifically, a client who is described as *isolated* would tend to evoke more linear-mechanistic assessment judgments in clinicians, an example of which would be "unilateral assessment" (as shown in figure 2). A client who is described as *involved* would tend to evoke more ecological-systems assessment judgments in clinicians, an example of which would be "mutuality by contracting" (as shown in figure 2).

Hypothesis-3b.

General: There is a positive correlation between measures of interpersonal-context of problem/situation, and measures of the kinds of intervention plans formulated by participating clinicians in specific practice situations.

Specific: More specifically, a client who is described as *isolated* would tend to evoke more linear-mechanistic intervention judgments in clinicians, an example of which would be "personality deficits" (as shown in figure 3). A client who is described as *involved* would tend to evoke more ecological-systems intervention judgments in clinicians, an example of which would be "personality strengths" (as shown in figure 3).

CHAPTER V

Method

General Statement

Hypothesis testing required the development of two instruments. The first, Instrument-1, measures differences in what social work student clinicians *say they believe* about their respective clinical orientations, with reference to their adherence to principles of one or the other of our two alternate approaches to practice. The second, Instrument-2, tests what social work student clinicians *say they would do*, under a variety of simulated circumstances.

Instrument-1 Development.

The first instrument (which appears in Appendix B) is based on an assumption that a series of contrasting "principles", drawn from the theoretical literature, could serve as a means of distinguishing beliefs about practice. The distinctions which are drawn in each "principle" refer to a *relative* presence (or absence) of one kind of orientation or another. Clusters of questions were then drawn up about each principle, in an effort to develop a questionnaire which would reliably distinguish between various aspects of our two approaches.

Initially, eight sets of comparative principles were developed for Instrument-1.

The initial eight sets of comparative principles were presented in Figure 1 as a theoretical, comparative understanding of the two schools of thought. The process of instrument development involved the testing of clinicians with questions which cluster around each principle. A final group of six principles (which are represented as six internally reliable instrument-scales) was arrived at. These were presented as the first six sets of principles in darker print in Figure 1. The two sets of principles in lighter print were eliminated in a process which will be explained in this chapter. The principles are numbered in the order in which they were initially drawn up. They are numbered according to that order throughout this study for the purpose of consistency. These principles are conceived as tapping a theoretical orientation which is represented in the totality of all six (final) principles together. *This viewpoint is based on the understanding that a theoretical orientation is not represented by any one aspect, but by the totality of all its aspects combined.* Anything less than the totality would be a different entity.

Instrument-2 Development.

The second instrument (which appears in Appendix C) actually tests our hypotheses under a variety of structured, controlled, simulated circumstances. It presents four specific case

vignettes of clients in *controlled*, differing practice situations, and asks clinicians for their assessments and intervention plans for each situation. This second instrument represents what clinicians *say they would do* in a practice situation. In this study, it is compared to what clinicians *say about their beliefs* in the first instrument. Measures of this comparison, under the differing experimental conditions of our four vignettes, constitute our results.

In order to develop the second instrument (which stayed close to actual concrete aspects of practice), sets of comparative, *operationalized* criteria, drawn from the literature, were formulated to describe the tasks of assessment (Figure 2) and intervention planning (Figure 3).

The second instrument included forced-choice and open-ended questions about actual assessment and intervention tasks. Each forced-choice question reflected one operationalized criterion. Each question was to be answered with *either* a linear-mechanistic *or* an ecological-systems form of assessment or intervention plan. Subjects were told to choose between one or the other, and could not pick a graded midpoint. This was done with the intent of evoking sharp contrasts in results.

The open-ended questions, on the other hand, were conceived as allowing for gradations between the two orientations. Subjects wrote freehand responses for assessment and intervention plans for each vignette. These free-hand responses were scored by trained

judges. The judges were trained to understand and to apply the criteria for assessment and for intervention plans, by arriving at a global rating for each open-ended response. A global score could be extreme or in-between. It represented the totality of all criteria considered. Each global score was conceived as the mean of the scores of each judge, for each open-ended response. Judges were all trained together, so as to consider criteria in a similar fashion.

The comparative criteria for assessment and intervention are the operationalized criteria by which the hypotheses have been tested. These criteria are presented in Figures 2 and 3, respectively, on the two following pages.

Structure of Hypotheses.

The hypotheses in this study derive from its specifying questions. The first two hypotheses (-1a and -1b) test the principal independent variable, *clinical-orientation*. These two hypotheses are indeed tested through the application of the preceding operationalized criteria, in both instrument-construction and data analysis procedures.

The second and third sets of hypotheses (-2a, -2b, -3a, and 3b) test for effects of the two secondary independent variables, *duration-severity* of problem/situation and *social-context* of problem/situation. These hypotheses are tested in both instrument-construction and data analysis procedures.

Choice of Subjects: General Statement.

Two alternatives were considered for choice of subjects to participate in this study. (a) It was thought that the use of *experienced social work clinicians* with substantive casework/direct-practice/micro-system level experience might generate responses which would contribute highly to variance and reliability. It became clear, however, that the cost in time and money would prohibit the location and use of a committed final sample of two hundred subjects to complete two or three questionnaires. (b) The location, through accredited schools of social work, of *second year students* with clinical/casework/direct-practice micro-system oriented training was more realistic. The maximizing of variance and reliability could be structured by using a large number of students from a variety of schools, on whom a dozen or so selection criteria (such as prior experience, and course of study) could be applied (in a process to be described at length in the next subsection of this chapter).

MSW programs in 1980, the year the data were collected, varied widely as reported by Dinerman (1981, p. 2), in curriculum structure and emphasis, but were expected to contain a number of broad areas of study in a coherent and integrated format. Required content comprised several headings, among which are included the following (Dinerman, 1981, p. 2; Council on Social Work Education, 1971, pp. 56-61):

1. Knowledge of *Human Behavior and the Social Environment*, which covered the contexts of individual, group, organizations, institutions and culture, was seen as bearing on behavior, and the theories about behavior which derive from biology, psychology, social science and humanities.

2. There was no mandate for a particular *Practice Approach* beyond and encouragement of an understanding of the relationship between knowledge, values and skill, inquiry, relationship to other human services approaches and personnel, and responsibility for social problem amelioration/prevention.

3. *Field work* was to enhance and reinforce curriculum while competence, values and skills developed.

Dinerman (1981, p. 11) notes that content areas and their rationale were specified only in general terms for Human Behavior and Social Environment "to permit experimentation in teaching practice based on the tradition of method [alone]...or combination of methods" (as in direct-practice or micro-level practice).

In her selective survey of MSW programs, Dinerman (1981, p. 11) notes that the Human Behavior and Social Environment area varied for different schools with a wide array of content possibilities. Most common were human Diversity, personality theories, and the situational-psychological interplay in human behavior, with a bent more in favor of the psychological factors. Common to all programs was the life cycle approach. Groups and community-oriented content tended to be not included (1981, p. 12).

Background and study concentrations among entering MSW students tended to be widely diverse (p. 41). For the large proportion of students, the MSW program is a *first* social work educational exposure (p. 66). Work with individuals and families was seen as a major focus. As pointed out by Fanshel in his introduction to Dinerman's study (p. xiv), "the variability among programs and the lack of order and predictability comes through quite strongly."

Thus we see in 1980, a diverse group of many inexperienced social work students with a varied backgrounds entering programs which provided a strong emphasis on psychological factors in the person-environment encounter, with much emphasis on work with (a) individuals and (b) families. As may be surmised from the earlier chapters, systems-oriented thinking and an interpersonal perspective in family practice was indeed present in the literature by the late 1970's. It would seem implicit that among a large group of casework/direct-practice/micro-system level second year MSW students in 1980, one might have found large numbers whose graduate curriculum and field work training reflected knowledge some family practice concepts of a systems and/or interpersonal nature, as well as individually-oriented psychologically-oriented knowledge. These would broadly reflect the choices between an individual and systems orientation with which the subjects were confronted in this study. Fully expounded ecological concepts were just entering the literature at that time.

Sequence of Procedures: General Statement.

Subjects who were ultimately included in the experiment were grouped categorically, according to their predominant use in practice of either (a) a linear-mechanistic approach (Group LM) or (b) an ecological-systems approach (Group ES). A middle group (Group M) was selected from among those subjects who fell into neither the LM nor ES groups.

Three instruments were utilized sequentially in the course of this study: An *Introductory Questionnaire* served to inform and select actual subjects, in a preliminary fashion, from the larger pool of potential subjects. *Instrument-1* and *Instrument-2* were developed to serve as the means to actually test hypotheses. The development and administration of these instruments were as follows:

Before the *Introductory Questionnaire* was utilized, letters were written to the Deans of all Council-on-Social-Work-Education-approved schools of social work in the United States and Canada. The study was explained and approval was requested in the form of then-current, soon-to-be second-year students in casework or direct practice. Fourteen schools responded with full, non-restrictive cooperation in providing the needed lists of students. A copy of the *Introductory Questionnaire* appears in Appendix A. Of the 1,007 questionnaires sent, over 700 were returned. Over 650 people indicated willingness and eligibility to participate. The questionnaire consisted of a letter which explained the study

along with a note of willingness to participate, on one side of a single sheet. The reverse side contained the questionnaire which asked twelve questions geared to elicit responses which included (a) confirmation of one's status as a second-year student in casework or direct practice. Questions also sought information about (b) current and future professional interests, (c) previous related academic and work experience, (d) age, (e) sex, and (f) school of social work attended.

Of the more than 650 students willing to participate, 200 were chosen to receive Instrument-1, based on the following criteria for eligibility found in their responses to the Introductory Questionnaire: (a) It was required that a participant respond to being a *second year student*, and (b) that both first and second-year *field placements* be in direct practice. (c) A current field placement in a mental health related setting was preferred, as a means of minimizing variance based on the influence of current field of practice. There was a preponderance of such participants. Additionally, one might surmise, that experience in such a setting lends itself well to practice in both models. Furthermore, the vignettes of Instrument-2 present participants with simulated practice situations which would traditionally be occur in a mental health setting. (d) *Primary professional interest* at the time had to be in working with individuals, families and/or groups. Interest which focused on agencies, organizations, and/or communities was *not* accepted. (e) *Career goals* had to be stated in words which indicated, or did not

preclude, a continued interest in direct practice or in a supervisory role in direct practice. (f) There was a large number of subjects with either *previous experience* in social work or a related helping profession, and/or a *prior masters degree* in a related field. It was thought that such prior experience might enhance a participant's understanding of work and theory-related issues in direct practice, and might thereby contribute to maximizing the variance of the final scores in our results.

(g) *Sex* of participants was addressed by attempts to balance the numbers of men and woman chosen. There were more women than men among the more than 650 willing respondents. In general, on a school-by-school basis, this involved the researcher's first selecting all or most of the otherwise eligible men (based on the criteria already noted); and then choosing an equal, or usually greater, number of women who fit the criteria for eligibility. This was done on a school-by-school basis. When, as was usually the case, there were too many eligible women from a particular school, choices were made by randomized selection among these women. (h) This brings us to the issue of the *representation of schools*. Our sample of 200 chosen participants is approximately 31% of our pool of just over 650 willing respondents. Therefore, approximately 31% of the total number of respondents per school was chosen as a means of proportionately representing each school in the sample of 200. In this sample, representation of participants by sex was fairly equalized with 96

men and 104 women. It was not possible, for reasons beyond this experimenter's control, to equalize the proportion of men and women on a school-by-school basis. Some schools presented far many more women than men for the pool.

In the ideal design, Instrument-1 was to be completed by a minimum of 120 subjects. It was designed to categorize each subject as to clinical-orientation, on a overall scale of 0.00 to 100.00. Ideally, the 20% of subjects falling closest to 0.00 comprise those to be categorized as utilizing a linear-mechanistic (LM) approach. The 20% whose responses score closest to 100.00 comprise those who utilize an ecological-systems (ES) approach. Subjects in the middle 20% constitute the middle (M) group. The second and fourth 20% groupings of subjects were to be discarded. Actual raw score does *not* determine group assignment. Rather, it is the *percentile rank* of each score which determines the clinical-orientation grouping to which each subject is assigned. Figure 4, below, illustrates this.

Figure 4. Percentile ranges of clinical-orientation groups for scores of Instrument-1.

Location of raw scores					
	0%	20%	40%	60%	80%	100%
	discard		discard			
Range of percentile ranking	0% to 20%		40% to 60%		60% to 100%	
	Group LM		Group M		Group ES	
	(n=24)	(n=24)	(n=24)	(n=24)	(n=24)	

Following the scoring of Instrument-1, twenty-four subjects were to be assigned to each group, for a total of seventy-two subjects for the experimental run. This is illustrated as follows:

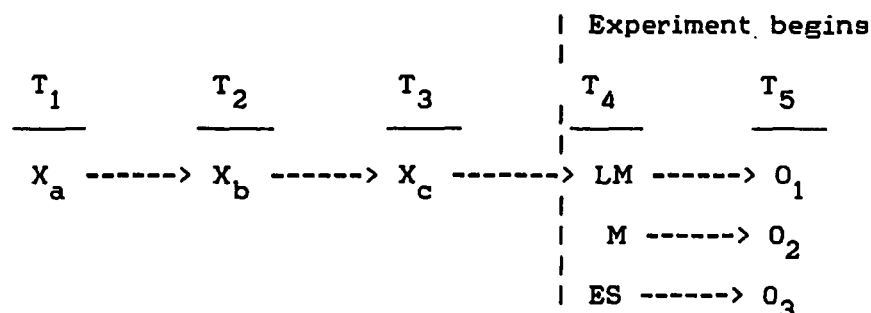
LM: n = 24
M: n = 24
ES: n = 24
<hr/> N = 72

Of the 200 subjects to whom Instrument-1 was sent by mail, 152 subjects actually completed and returned these.

At a later date (a few months later), after subjects had initially been categorized into three experimental groups, the experiment was run by mailing Instrument-2 to the subjects in the three groups. This consisted of a series of four written case vignettes which were presented to each subject to read, followed by a request to respond immediately to a questionnaire about each vignette.

Data for the experiment consists of responses to Instruments-1 and -2. Data analysis explored the responses in each experimental group (LM, M, ES) to test for the effects of the main independent variable, clinical-orientation; and to test for the effects of the two secondary independent variables, interpersonal-context and duration-severity of problem/situation. The design sequence ran as follows.

Figure 5. Time sequences of events in this study.



- T_1 : Located pool of subjects and arranged for their participation. (X_a) This includes the scoring of the Introductory Questionnaire and the selecting of a sample.
- T_2 : Administered Instrument-1 to all subjects in sample. (X_b)
- T_3 : Analyzed data from Instrument-1 in order to group subjects in either LM, M or ES, or to discard them. (X_c)
- T_4 : Administered Instrument-2 to subjects in LM, M and ES.
- T_5 : Analyzed responses to Instrument-2 and tested hypotheses.

Instrument-2 carries a series of four case vignettes which were constructed for all subjects to read and immediately react to, by responding to a questionnaire after each vignette. The final versions of the four vignettes were developed through a pilot project which involved the pretesting of a group of professional social workers, followed by discussing with each of them the purpose of the vignettes, as well as their critiques of and suggestions about the content and format of the vignettes.

Structure and Presentation of the Vignettes.

Each vignette is composed of one of two extreme *interpersonal-context* categories (*isolated* or *involved*); and one of two extreme *duration-severity* categories (*acute* or *chronic*). There are four such combinations to form four case vignettes which represent groupings of extreme differences in types of problem/situation which a clinician may encounter. For example, these differences, might be seen as lending themselves (a) to significant differences in case conceptualization (i.e., individual versus environmental focus in assessment); and (b) to significant differences in intervention/treatment plan (i.e., emphasis on individual insight versus emphasis on more broadly based family support).

The vignettes are brief and clear, to maintain the reader's interest and ability to follow them. They do, however, provide sufficient information to enable a clinician to make judgments from either a linear-mechanistic or an ecological-systems perspective. Figure 6 illustrates the four types of vignettes developed.

Figure 6. The four combinations of interpersonal-context and duration-severity utilized in vignette development.

<u>Duration-severity</u>	<u>Interpersonal-context</u>
1. Acute adjustment reaction, developmental crisis of young adulthood.	a. Lives alone, in isolated fashion.
2. Chronic psychotic state of young adulthood.	b. Lives with support of an intact family.

To recapitulate, two extreme duration-severity categories and two extreme interpersonal-context categories were chosen. These categories were combined into the four possible types of vignettes. The vignettes have clear similarities and distinguishing differences which might affect results.

1. *Similarity* lies in the *developmental stage* of clients. All clients are in early adulthood. This eliminates stage of life as a variable.

2. There are *differences* in *interpersonal-context* categories:
(a) A person who lives alone in an isolated fashion, might be more easily assessed and engaged in individual interventions, which reflect a linear-mechanistic viewpoint, based on a lack of readily discernible environmental factors. (b) An individual in an intact family living situation would be more easily assessed and engaged in the framework of an ecological-systems approach because of the readily discernible environmental factors.

3. *Differences* for the two *duration-severity* categories might also reflect differences between the two orientations: linear-mechanistic versus ecological-systems. Thus, a client with a chronic condition might be prone to be seen from a linear-mechanistic perspective. By the same token, an acutely suffering individual might tend to be seen more from an ecological-systems perspective.

There are four vignettes which are numbered on the basis of the prior illustration in Figure 6.

- (1-a) Acute adjustment reaction of young adulthood, for an individual who has left home and lives alone.
- (1-b) Acute adjustment reaction of young adulthood for an individual who lives in an intact family.
- (2-a) Chronic psychotic state for a young adult who lives alone.
- (2-b) Chronic psychotic state for a young adult who lives in an intact family.

The four vignettes follow in Figures 7,8,9 and 10.

Figure 7. Case vignette-1a (acute-isolated condition).

David is age twenty. His parents, recently divorced professionals, had always been materially and affectionately generous to David. Their generosity became more pronounced five years ago after David's only brother completed college, married and moved out West. Parents' marriage had centered around providing for the children. The family had always lived in a small neighborly New England town.

David, due to be a senior in a college near home in the fall, says his parents expect him to go to graduate school, but that he has not even looked into this. Instead, he has been thinking about, and talking to his friends, parents and college advisor about leaving home where he lives with father and finishing college somewhere else.

David has been edgy at home. He and father have been openly hostile to one another for the past year. He avoids much contact with mother who lives in the same town. He had been dating a young woman whom he had known since high school but felt he was only seeing her more recently because she kept him away from home where he hated to be.

David came far to this city three weeks ago. He called his mother last week, long distance, collect, to say that he is fine and has money, but would not give his address. When David left home, he and his father were not on speaking terms.

David was referred to this agency by a friend who lives at the "Y" where David is Staying. David expects to run out of money in about a month and says he does not know what he will do then. He dislikes the impersonal atmosphere at the "Y" but is having a good time meeting people in New York.

David's complaints include feeling that his parents bother him, that there is really nothing for him in his home town, and that he needs to think things out away from home, perhaps permanently.

David wants help in deciding what to do. He wants a "counselor" to help him think things out. He does not want a therapist to get into his head.

Figure 8. Case vignette 1-b (acute-involved condition).

Martha, age nineteen, is living in the City with her parents and only sister age sixteen. Mother is a teacher and is home late afternoon every day. Father is a businessman, does very well financially, but keeps very long work hours. Martha is in her second year at city college. She entered college after completing art high school a year ago.

Martha's college advisor referred her to this agency after several talks with Martha. Martha also spoke with her mother about her distress.

Martha's complaints include anxiety and short-temperedness at home and with friends. Martha says her mother complains about her childishness, lack of cooperation at home, and late hours. Martha says her mother refuses to understand her and that she'll do as she pleases.

Martha has a good relationship with her college advisor. She participates in some school activities, and has a regular group of friends to whom she complains often about her mother, as well as about the men she dates. Martha speaks fondly about her father, but with lots of ambivalence in her open recognition that he is never home and never does anything with the family the way he used to.

Martha wants to feel less anxious about her school work which remains academically exceptional. She wants very much to feel less anxious about men and dating, and generally about making decisions herself. She also wants her mother to get off her back. Her college advisor, who referred her for help, remains interested and available, as is her mother.

Figure 9. Case vignette 2-a (chronic-isolated condition).

John Smith, age twenty-four, has one brother age twenty-seven. Parents died when John was in his late teens. He has had no contact with his brother for the past three years, although his brother has tried to help him.

John earned a college diploma in engineering three or four years ago. Work and living history are unclear since John was graduated from college and left his brother's home in Philadelphia to live in this City. Since then he has lived in transient fashion in both cities, where he spent a good part of his childhood. He has lived in transient hotels supported by public assistance for the past two or three years. He spends lots of time at the movies, in parks, and in his hotel rooms. He has no friend, and says he really does not need any.

John is seen regularly for brief appointments for medication renewal at the outpatient psychiatric clinic of a large local hospital. He says the medication keeps him calm.

John was referred to this agency through a social worker assigned to our new multifaceted community outreach program which covers the hotel where John lives. They spoke for about half an hour this morning and John came to this agency this very afternoon asking to be seen.

John is not sure why he is coming to this agency for help, except that he was told that we might be able to help him with his situation. He does not seem to really understand what that means. He has some generalized intellectualized notions that "life can be more interesting," but he says he hasn't the vaguest idea as to how to go about it. He doesn't acknowledge anxiety when asked about his work history. He does, however, reveal that he lost his first professional engineering job after college for cursing at his supervisor. He has not been able to work since then.

Figure 10. Case vignette 2-b (chronic-involved condition).

Mary Jones, age twenty-four, is two years younger than her only brother. Her brother is married, has a child, is successful in his new business, and is living in the City. Mary has always lived with her parents who are now semi-retired in their mid-sixties. Brother and his family are frequent visitors, and are always helping out, doing favors for parents and sister. Mary's mother is controlling, dominating, pivotal in the household. Her father is emotionally distant and passive.

Since the age of seventeen, Mary has had several periods of psychiatric hospitalization. She has held several clerical jobs for brief periods, and has either quit "because of the pressure," or been fired. She has always lived home, except for brief periods in a halfway house after two of her hospitalizations.

Referral was made to this agency by the social worker at the halfway house which Mary recently left after a stay of a few weeks to return to live with her parents. The halfway house staff had, however, recommended that she not go home but continue to live there for at least a year.

Her complaints include serious anxiety about any new venture, times when she feels like she is floating, and episodes of hallucinations. When she is lucid, she has a sense that not only is she a real failure, but that even when she tries to succeed, at a job or at the halfway house, someone underhandedly causes her to fail.

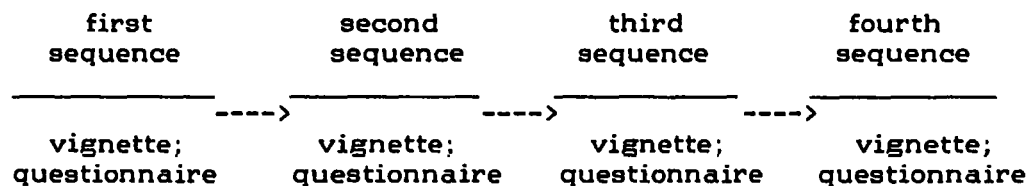
Although she has taken various sorts of psychotropic medication for the past several years, Mary has never had shock therapy. She has also never seen the same therapist for more than a year.

Mary wants to feel better. She does not want to have to go in and out of hospitals all her life. She says, when asked, that she wants her brother to offer to take care of her when her parents die or become too old, which is one of her greatest and most haunting fears.

Each series of case presentations consisted of the four vignettes in one of twenty-four possible sequences. There are $4 \times 3 \times 2 \times 1 = 24$ possible permutations or sequences. Each possible sequence was to be presented once to each of our three groups.

Each vignette in each series of four was to be read by a subject who would respond immediately to the questions in Instrument-2. Thus, a vignette, followed by the Instrument-2 questionnaire, would be presented four times to each subject. This is illustrated in Figure 11.

Figure 11. Alternation sequences of presentation of vignettes and questionnaires in Instrument-2.



Ideally, there would be twenty-four subjects in each of the three experimental groups. Each subject would be assigned to one of the twenty-four presentation sequences in a group. Final tabulations actually were of twenty-one (21) subjects in each group, for a total of sixty-three (63) subjects. The events leading to this change will be described later in this narrative. This change is illustrated as follows:

<u>Group</u>	<u>Ideal totals</u>	<u>Actual totals</u>
LM:	n = 24	n = 21
M:	n = 24	n = 21
ES:	n = 24	n = 21
	N = 72	N = 63

Each group was to be given the same twenty-four permutations of vignette presentations. This allows us to counterbalance the sequences of presentations. Counterbalancing enables us to deal with unforeseen effects. These may be effects of learning, of fatigue, or of the effects of the subject matter of a particular vignette on a particular clinician. These effects may skew the responses of particular subjects to particular vignettes. Counterbalancing is a technique which is preferable, in this case, to random order presentation, because we want each subject to be exposed to each vignette. In random sequence presentations, one subject may be exposed to the same vignette more than once, yet not be exposed to all four vignettes. This technique of counterbalancing was utilized by Orcutt (1962, 48-49, 53) in her dissertation research.

Figure 12, which follows, illustrates the twenty-four possible orders of vignette presentation to be given to subjects within each of our three groups.

Figure 12. Twenty-four permutations of case vignette presentations.

<u>Series no.</u>	<u>Presentation order</u>
1	1a, 1b, 2a, 2b
2	1a, 2a, 1b, 2b
3	1a, 1b, 2b, 2a
4	1a, 2a, 2b, 1b
5	1a, 2b, 2a, 1b
6	1a, 2b, 1b, 2a
7	2a, 2b, 1a, 1b
8	2a, 1a, 2b, 1b
9	2a, 2b, 1b, 1a
10	2a, 1a, 1b, 2b
11	2a, 1b, 1a, 2b
12	2a, 1b, 2b, 1a
13	1b, 1a, 2b, 2a
14	1b, 2b, 1a, 2a
15	1b, 1a, 2a, 2b
16	1b, 2b, 2a, 1a
17	1b, 2a, 2b, 1a
18	1b, 2a, 1a, 2b
19	2b, 2a, 1b, 1a
20	2b, 1b, 2a, 1b
21	2b, 2a, 1a, 1b
22	2b, 1b, 1a, 2a
23	2b, 1a, 1b, 2a
24	2b, 1a, 2a, 1b

Instrument-2 is solicits measures of our two dependent variables, assessments and intervention plans. It solicits these measures through both open-ended and forced-choice questions. Scoring for each subject, on each of the four vignettes, is on the basis of scores for (a) open-ended and (b) forced-choice responses for assessments and for intervention plans.

The open-ended and forced-choice scores are not treated as being additive with one another, since the methods for soliciting these scores were different. The open-ended scores were derived from procedures which utilized outside raters. The forced-choice

scores were subjects' actual own ratings. Thus, open-ended and forced-choice responses will be treated separately in our results.

Reliability Testing of Instrument-1 and Scoring of its Final Format.

Of the sample of 200 subjects selected to receive the tested version of Instrument-1, 152 scorable forms were returned. This version of Instrument-1 contained fifty items which were divided into eight scales according to eight "principles". The "principles" which were previously illustrated in figure 1, were developed from the literature as theoretical distinctions between linear-mechanistic and ecological-systems orientations.

On the basis of scores on the fifty-item tested format, subjects were divided into three groups: a low-scoring LM group; a mid-scoring M group; and a high-scoring ES group. On the basis of membership in one of these three groups, Instrument-2 was administered to subjects. The procedure was a technical error, because reliability-testing had not yet been done on the fifty-item version of Instrument-1 whose scores had served as the basis for the experimental groupings. Therefore, reliability-tested, retroactively-corrected regroupings of subjects were arranged from the initial three groups. This was done *after* subjects had completed their responses to Instrument-2. These regroupings (happily) retained a workable distribution of subjects' scores.

The regroupings were the result of a process of establishing *internal reliability* for Instrument-1. This process resulted in the

elimination of twenty-three items from Instrument-1, which was reduced to twenty-seven items. (a) Items were eliminated whose values had been contributing to reduced values of Cronbach's Alpha coefficients for each of the Instrument's eight scales. (b) Item-deletion was also based on an item's point-biserial correlation with (1) the total score of the entire instrument, and (2) with the total score of the particular scale to which it belonged. In general, items having a point-biserial coefficient of less than .30 for the entire instrument, and/or for its respective scale, were deleted. Item-deletion was an iterative process, whereby reliability was assessed and reassessed upon each item's deletion. In the end, the total number of items in the instrument (and in all scales but Scale-1) was reduced. The instrument was reduced from fifty to twenty-seven items. Scales 2 and 7 were eliminated in the process.

As a result of this process, (a) a few subjects were shifted from one group to another, and (b) a small number ended up in the discarded groups. Although this resulted in a few subjects being "lost," it was nonetheless possible to maintain statistically viable group compositions of $n=21$ for each of the three groups, with a total of $N=63$. At this juncture, group size was reduced, as previously noted. Of significance, however, is that all three groups were designed to contain equal numbers of subjects, so as not to complicate data analysis with a potential problem of unequal group sizes.

Below, in Table 1, are the six scales which survive after the whittling away of items with low reliability coefficients. They replicate in abbreviated form Figure 1 in Chapter I, *comparative principles which underlie a linear-mechanistic approach and an ecological-systems approach*. Instrument-1, with a highlighting of its final twenty-seven items, may be found in Appendix B.

Table 1

Point-biserial correlations between item scores and subscale total scores for the six final scales of Instrument-1, and between item scores and total score of overall Instrument-1

Scales:			Specific	Total	Point	
No.	Name		scale	no.of	biserial	Alpha
			items	items	median	
1	Linear causality equifinality	versus	#1,2,3,4,5, 6,7,8,9,10	10	.35	.71
3	Analytic quality organismic quality	versus	#20,22	2	.66	.79
4	Homeostasis heterostasis	versus	#24,25,26, 27,28,29	6	.62	.84
5	Mind-body dualism holism (rejection of dualism)	versus	#31,32,33	3	.63	.79
6	Entropy negentropy	versus	#34,35,36	3	.88	.95
8	Isolated intervention life-context intervention	versus	#47,48,49	3	.82	.88
All six scales as one instrument				27	-	.74

* There is some inflation in the coefficients, because each subscale total score includes the item with which it is correlated. Refer to Appendix B for a full listing of all 27 items according to scale.

Table 1 reveals a high degree of correlation between each subscale score and the total instrument score. It also reveals an acceptable degree of reliability for each scale.

Discussion of the relationship between the total final Instrument-1 and its six subscales follows Table 2, which appears next. That table presents a correlation matrix for each scale for the total scores of all groups combined.

Table 2

Intercorrelation matrix of the six scales of Instrument-1,
with one another, and with the total score of each scale,
for all groups combined

<u>Scale</u>	<u>One</u>	<u>Three</u>	<u>Four</u>	<u>Five</u>	<u>Six</u>	<u>Eight</u>
One						
Three	30*					
Four	17	12				
Five	19	37*	11			
Six	-01	13	28*	19		
Eight	10	24	10	06	-18	
Total	65*	56*	63*	50*	41*	33*

Note: Entries are Pearson correlation coefficients with decimal points removed.

* $p \leq .05$

Table 2 illustrates a clear pattern of statistical significance for correlations of scales to the *total* Instrument-1, when all three groups were combined. This occurred only with regard to the combining of all three groups. *Each* correlation of scale-score with the total score of Instrument-1 is positive, and *each* is significantly different from zero. Otherwise, most correlations do not obtain significance, and in two cases are negative (i.e., Scale 1 with Scale 6, and Scale 6 with Scale 8). Scales 6 and 8 do not fit as well with the four remaining scales as those four scales fit with one another.

Data Collection for Instrument-2.

Seventy (70) subjects (of which sixty-three were ultimately utilized), in Groups LM, M, and ES, completed Instrument-2. The instrument consists of open-ended and forced-choice items. Instrument-2 appears in Appendix C.

One open-ended item (which appears as Question #1) inquires about the clinician's overall assessment of each of the four case vignettes. A second open-ended item (Question #2) inquires about the clinician's overall intervention plan for each of the four vignettes.

Five forced choice assessment items appear in Instrument-2 as Questions #3 to #7. Nine forced-choice intervention items appear in Instrument-2 as Questions #8 to #16. These inquire about a clinician's thinking. Each item represents one

operationalized set of comparative criteria about one aspect or parameter of assessment or of intervention plans, exactly as presented previously in Figures 2 and 3.

As noted earlier, the questions in Instrument-2 appear four times, once after each case vignette. Clinicians who respond to Instrument-2 are asked to think of themselves, in practice, as being halfway through a first face-to-face client-contact, at their current agency. This is the point at which the clinician may indeed begin to think about assessment and intervention plans. It is traditionally part of an agency's intake process.

Data for open-ended items was collected as the free-handedly written responses of subjects. These responses were then scored by raters via procedures which were developed and applied as follows:

1. Of the three raters (*excluding* the researcher), two were experienced clinical social workers; the third was a psychometrician.

2. The raters each read the full research proposal. They specifically studied Figure 1, which describes "principles", and Figures 2 and 3 which describe "comparative criteria". They also specifically studied the vignettes and the rationale behind them.

3. The researcher then met with the three raters for a four and one-half hour initial training session, during which they reviewed all they had studied, and specifically discussed "operationalized criteria" for the rating of responses. Responses which the researcher, as "expert", considered to be exemplary of linear-mechanistic and ecological-systems perspectives, were reviewed. They then practiced applying the criteria to ratings, and refined the use of the criteria as rating tools, in the process.

4. Seventy-seven (77) responses were scored as exemplary of extreme and middle-range scores.

5. Each rater scored responses on an integer scale of zero (0) to four (4), where "0" is fully linear-mechanistic (with *no* ecosystems aspects); "4" is fully ecological-systems (with *no* evidence of a linear-mechanistic view); and "2" is uncertain, mixed or unclear. "N" signifies not-scorable, and is reserved

only for responses which are so *sparse* that a rating becomes *impossible*. Other rating choices are "1" or "3".

6. Responses were considered "unproblematic" where there was full agreement (i.e., all raters gave the *same* score), or where there was a difference of only *one* point among the raters (e.g., two raters gave a score of "1", and one rater gave a score of "2").

7. All response-ratings which did not meet the requirements for being "unproblematic", were considered to be "problematic". The problematic designation also included any rating of "N".

8. Conferences were held to discuss *each* "problematic" response-rating, and a few "unproblematic" ones as well. The goals were to understand differences among raters, and to clarify and develop guidelines for the systematic application of criteria by all three raters. The outcome of the conferences, in the large majority of cases, was either full agreement among raters, or a difference of only one point among them. It is seen as positive evidence for the validity of criteria utilized by the judges in their assignment of ratings that, in *some* instances, despite long discussion, one or two raters refused to change a score, and offered evidence taken from actual responses to support a particular rating. Such periodic, unwavering perceptions, evidenced across all points on the rating scale, may be seen as evidence for the validity of the ratings.

9. Then, a series of 114 responses, was given to the raters, to score totally *independently*. These were chosen by the researcher, as expert, for their varied qualities which were exemplary of the range of possible scores. It was planned that if reliability estimates obtained from these ratings were acceptable, then these scores would be utilized as part of our final results. We would then procede with the rest of the rating process. Of 114 sets of ratings, 105 (or 92%) fully met our criterion for inter-rater agreement. Of the nine (9) sets of ratings (or 8%) which did not meet our criterion for inter-rater agreement, five (or 6%) almost did so.

10. Based on these *favorable results*, following discussion with the three raters, the remaining $[560-114=]$ 446 responses were scored *independently* by the raters. All responses which had been rated earlier in the training/practice process were rescored along with the large majority of responses which had never been scored. The fact that some had once been scored and discussed at an earlier time is seen as having minimal or no impact on the final results, because raters had no stake in replicating any prior results. Furthermore, previously rated responses were not visibly identified. In fact, given that many responses indeed sounded similar to one another, it is unlikely that a rater would actually have recalled a previously discussed response, nor the rating which had been attached to it in the training process. Also, there was a time interval of eight to twelve weeks between the training ratings and the period of final scoring. Therefore,

raters' memories would be expected to have lapsed over time for previously scored responses, which were then presented in an unidentified and random order as part of the "final" 446 responses to be rated. In addition, there had been an intervening set of 114 responses, (our first group of "final ratings",) which also served to attenuate the memories of raters for the specific recall of any ratings which they had previously assigned.

11. Given that there are eight open-ended responses per Instrument-2, the total of 560 ratings represents $(70 \times 8 =)$ 560 response ratings per judge. This *includes* the $(63 \times 8 =)$ 504 response ratings per judge for the sixty-three (63) subjects whose responses formed the final data base for Instrument-2.

Data collection of forced-choice responses was a far simpler matter than for open-ended responses. Each response-choice was made by the clinician-subject directly. Each item was then simply scored by the researcher as either "0", if the clinician had chosen the "linear-mechanistic" response, or as "4", if the clinician had chosen the "ecological-systems" response.

Data Tabulation and Analysis: Introduction.

As noted, the open-ended and forced-choice scores are treated separately, as *not* additive with one another, because methods for their solicitation were distinct. We recapitulate below.

The open-ended scores were derived via carefully applied procedures in which outside raters scored free-style written

responses of subjects whom they did not know. The forced-choice scores, however, were derived directly from subjects' responses to specific questions. The questions were based on operationalized criteria about practice which appear in Figures 2 and 3. These criteria, drawn from the literature, were developed to describe the tasks of assessment and intervention planning.

These criteria do, however, visibly relate to the "principles" which were addressed in the questions in Instrument-1. The dimensions addressed by Instrument-1 "principles", and by Instrument-2 "criteria" indeed reflect similarities. Thus, to subjects' eyes, the *forced-choice questions* may in some way emulate the earlier questions of Instrument-1, since each set of questions makes salient the dimensions involved in Instrument-1 and Instrument-2, respectively. In the *open-ended questions*, however, this salience of common dimensions is *not* forthcoming to the clinician. Therefore, the clinician-subject is left sitting with the "pull" of each specific vignette, without any structured questions about orientation which might affect that "pull".

Thus, one might expect the pull of the specific dimensions, which define linear-mechanistic *versus* ecological-systems, to come to the fore with our more structured, forced-choice questions. By the same token, however, one might expect that the totally unstructured open-ended questions would more freely highlight and draw out the embedded of duration-severity and interpersonal-context which were not alluded to in any questions of either instrument.

Data Tabulation and Analysis: Explanation.

Open-ended response scores were conceived as interval measures of *continuous* data, to be treated by an analysis of variance.

It was, however, observed that *forced-choice response scores* could be conceptualized (and therefore treated) in two ways:

1. At first, *forced-choice* scores had been conceptualized as end-points on a *continuous scale* for which middle-range scores (which include mixed gradations) exist, but had not been offered as response alternatives. These had not been offered in an effort to "force" sharp differences. Clinicians are, nevertheless, seen as learning and utilizing gradations and ranges of alternatives in assessments and interventions. The balance in any particular case would reflect a weighting toward one or another set of operational alternatives in the choice of assessments and intervention plans which reflect either a more linear-mechanistic or a more ecologicalsystems approach in a particular case.

Furthermore, each forced-choice question derives directly from an operationalized criterion for assessment or intervention. These criteria were conceived as partialized aspects of a total way of working. It is therefore the *totality* of operational choices which makes each assessment and each intervention plan relatively more linear-mechanistic or more ecological-systems, and not any one particular criterion taken out of context. Therefore, it is the respective *aggregate of scores for all five assessment and all nine intervention items* which are primary to this collection of data,

and not individual item-scores. (Mean scores, it is worth noting, rather than simple totals, were chosen as the aggregate scores, in order to prevent an occasional missing value from skewing our results.)

2. It was subsequently observed that despite the initial working concept of "forcing" subjects to declare end-point choices on a continuous scale, an alternative view was possible. We could, in fact, make a case for treating forced-choice responses as *discrete* data. Thus, the two response alternatives to each forced-choice question could be seen dichotomous and unrelated. This would allow us to conceptualize our response-choices as binary measures. These measures could then be adjunctively tested, item-by-item, for significance, through chi-square tests. Each item would be tested separately, because binary, chi-square data cannot incorporate the totality of items. This would provide us with interesting data about each item (and about the respective operational criterion from which each item derives).

Analysis of variance was utilized to test continuous data, which was conceptualized as being scored on an interval scale, for both open-ended and forced-choice responses. Figure 13, which follows, was adapted from B.J. Winer's (1971, p. 284) discussion of computational measures through which to derive analysis of variance scores. That schema presents, in detail, the three sources of variance in the independent variables. The twelve cells for response-scores represent results which were repeated separately for assessment and for intervention scores.

Figure 13. Sources of variance with schema for the tabulation of results.

Independ. variable No. Name		Condition			
3.Int'pers.-context		Isolated		Involved	
2.Duration-severity		Acute- reactive	Chronic- psychotic	Acute- reactive	Chronic- psychotic
1.Clinical-orient'n					
<u>Group</u>	<u>Scores</u>				
LM -->	1				
	2				
	3				
	.				
	.				
	21				
M -->	1				
	2				
	3				
	.				
	.				
	21				
ES -->	1				
	2				
	3				
	.				
	.				
	21				

A word is given about the actual data utilized. For open-ended responses, the judges' choices for scoring were on a scale of "0" to "4". As noted, a score of "0" represented the most linear-mechanistic choice for assessment and intervention, while a score of "4" indicated the most ecological-systems choice. The actual working score for each open-ended response, for each subject, is the *mean of all three judges' ratings* for a subject's response to a particular item. For example, for a particular clinician for vignette #1a, each judge read and rated the response to the question: "What is your overall assessment of this situation?" Judge-1 may have rated the clinician's response as 3, and Judge-2 may have also given it a rating of 3. Judge-3, however, may have given the response a rating of 2. A mean of 2.67 would be the working score which would be used in calculations for analysis of variance.

For forced-choice responses, the scores utilized are the aggregate means of the five assessment items and of the nine intervention items scored by each subject, for each vignette-situation. For example, for vignette #1a, each subject read and responded to the five assessment questions. Thus, if a clinician's responses to these five questions respectively were 4, 1, 4, 4 and 2, then the score for that subject's assessment of vignette #1a would be a mean of "3". This is a relatively ecological-systems mean, despite the fact that there is one linear-mechanistic score (1), one middle score (2) and three strongly ecological-systems scores (4). The mean of 3 would have been the actual aggregate score to be tallied in the calculations for analysis of variance.

CHAPTER VI

Results

Introduction.

Data from Instrument-2 takes two forms: (a) mean scores of the three raters for each open-ended response, and (b) scores of the forced-choice items, both of which are examined in clusters according to our three independent variables (clinical-orientation, interpersonal-context and duration-severity).

In order to present our data as meaningful results, however, a number of steps are necessary. (a) We first assess inter-rater reliability for the three judges who scored our open-ended questions. (b) We then assess mean group differences for the open-ended item-scores through analysis of variance. (c) Next, we assess mean group differences among forced-choice scores through analysis of variance. (d) We do this in conjunction with a brief highlighting of findings about response frequencies across groups through chi-square analysis of forced-choice scores. All analyses are done separately for assessment data and for intervention data.

The intention is to lead upto a presentation of results about the hypotheses in a systematic manner, and then discuss the meaning of our results in a manner which highlights principal findings.

Inter-Rater Reliability: Open-Ended Assessment Scores of Instrument-2.

Pearson correlation coefficients among the three raters are presented in Table 3. Coefficients are provided for *each* clinical-orientation group, as well as for *all* groups combined in all secondary variable conditions. With regard to the analysis of each group, five of thirty-six coefficients were found to be non-significantly different from zero. *All* of these low coefficients were found for vignettes where the duration-severity was acute. Four of these coefficients also were for the acute-isolated condition; one was for the acute-involved condition. The intercorrelations shown in Table 3, which follows, indicate that the correlation-scores of Rater-1 with Rater-2 are consistently high and statistically significant. Intercorrelations of Rater-3 with either Rater-1 or Rater-2 are also statistically significant, although they are also visibly lower. This trend is constant within each of the three subject-groups, as well as for all groups combined, although it did *not* significantly affect reliability. Thus, we may conjecture that Rater-3 (a psychometrician) may not have evaluated the assessment open-ended responses of subjects in a manner which would be similar to Raters 1 and 2 (clinical social workers).

On the overall, a very *high degree of reliability* exists across assessment scores.

Table 3

Inter-rater reliabilities of the three judges who rated the
assessment open-ended questions of Instrument-2

Interpersonal- context (and rater)	Clinical-orientation			
	Group LM (n=21)	Group M (n=21)	Group ES (n=21)	All groups (N=63)
<i>Acute duration-severity</i>				
<u>Isolated</u>				
(1 and 2)	87*	84*	92*	87*
(1 and 3)	-05	67*	49*	36*
(2 and 3)	31*	52*	35*	42*
<u>Involved</u>				
(1 and 2)	90*	73*	67*	93*
(1 and 3)	57*	20	13	63*
(2 and 3)	48*	-09	07	60*
<i>Chronic duration-severity</i>				
<u>Isolated</u>				
(1 and 2)	84*	84*	100*	88*
(1 and 3)	35*	37*	86*	55*
(2 and 3)	57*	44*	86*	67*
<u>Involved</u>				
(1 and 2)	100*	94*	100*	98*
(1 and 3)	42*	76*	76*	64*
(2 and 3)	42*	83*	75*	66*

Note: Entries are Pearson correlation coefficients with decimal points removed.

* $p \leq .05$

Inter-Rater Reliability: Open-Ended Intervention Scores of
Instrument-2

Inter-rater reliability for the open-ended intervention scores show a similar pattern of reliability coefficients as is seen in our assessment data.

As with the assessment data, Rater-1 consistently shows a high degree of correlation with Rater-2. The scores of Rater-3 correlated moderately with those of Rater-1 and Rater-2. Again, as with assessment data, the results indicate that Rater-3, (a psychometrician) did not assign scores in a manner similar to that of Rater-1 and Rater-2 (both clinical social workers). Yet, except for the chronic-isolated condition for Group LM, there is a very *high degree of reliability* with statistically significant correlations across responses for all three raters.

Table 4

Inter-rater reliabilities of the three judges who rated the
intervention open-ended questions of Instrument-2

Interpersonal- context (and rater)	Clinical-orientation			
	Group LM (n=21)	Group M (n=21)	Group ES (n=21)	All groups (N=63)
<i>Acute duration-severity</i>				
<u>Isolated</u>				
(1 and 2)	100*	92*	85*	91*
(1 and 3)	48*	68*	76*	62*
(2 and 3)	48*	70*	67*	60*
<u>Involved</u>				
(1 and 2)	95*	100*	74*	90*
(1 and 3)	69*	56*	76*	67*
(2 and 3)	75*	56*	67*	65*
<i>Chronic duration-severity</i>				
<u>Isolated</u>				
(1 and 2)	90*	96*	96*	94*
(1 and 3)	23	60*	48*	41*
(2 and 3)	06	55*	42*	35*
<u>Involved</u>				
(1 and 2)	97*	86*	92*	93*
(1 and 3)	77*	48*	38*	56*
(2 and 3)	76*	41*	44*	55*

Note: Entries are Pearson correlation coefficients with decimal points removed.

* $p \leq .05$

Instrument-2, Open-Ended Questions: General Statement.

Analysis of variance for assessment and for intervention plans involves three factors. The main independent variable, clinical-orientation, is represented by the groups, LM, M and ES. The other two factors are the secondary independent variables, duration-severity (acute *versus* chronic), and interpersonal-context (isolated *versus* involved). Subjects' response scores were analyzed separately for assessment and for intervention procedures. No hypotheses were presented for interactional effects between assessment and intervention measures. The analysis of variance procedure, therefore, is a $3 \times 2 \times 2$ (group \times duration \times context) ANOVA, with repeated measures on the last two factors.

A fourth factor, however, is that of rater (or "Judge"). Of concern is whether judges' ratings differ significantly from one another with respect to the three independent variables or the interactions among those variables. A finding of any significant main effects or interactions with the factor judge would indicate differential ratings by judges. Such a finding would call for a separate analysis of each judge's ratings, because the use of a mean rating for all judges combined might mask the true effects of our findings.

Analysis of Variance for Assessment: Open-Ended Questions.

A $3 \times 2 \times 2 \times 3$ (group \times duration \times context \times judge) ANOVA with repeated measures on the last three factors was performed on the assessment data, as shown in Table 5.

Table 5

Four-way analysis of variance for open-ended assessment responses

Source	Sum of squares	Degrees of freedom	Mean square	F
Judge	0.07	2	0.03	0.16
Judge x Group	0.58	4	0.14	0.69
Error	23.68	112	0.21	
Duration	137.71	1	137.71	145.29**
Duration x Group	13.77	2	6.88	7.26**
Error	53.08	56	0.95	
Context	30.08	1	30.08	16.05**
Context x Group	0.11	2	0.06	0.03
Error	104.95	56	1.87	
Group	2.83	2	1.42	0.71
Error	111.34	56	1.99	
Duration x Context	13.34	1	13.34	13.44**
D'tion x C'text x Grp	2.91	2	1.46	1.47
Error	55.57	56	0.99	
Duration x Judge	0.49	2	0.24	1.05
D'tion x Judge x Grp	0.16	4	0.04	0.18
Error	26.02	112	0.23	
Context x Judge	0.49	2	0.24	1.08
C'text x Judge x Grp	1.47	4	0.37	1.63
Error	25.37	112	0.23	
D'tion x C'text x Judge	0.04	2	0.02	0.11
D'tion x C'text x Judge x Group	1.19	4	0.30	1.87
Error	17.78	112	0.16	

** $p \leq .01$

Group (or Grp) = clinical-orientation group

Duration (or D'tion) = duration-severity

Context (or C'text) = interpersonal-context

There were no statistically significant group differences. Yet, the factor group did interact significantly with duration-severity as illustrated in Table 6.

Table 6 shows chronicity as evincing lower (more linear-mechanistic) scores for within-group comparisons of LM, M and ES.

For conditions which involve chronic duration-severity, a trend supports the main hypothesis: Mean scores for Group LM are somewhat lower (more linear-mechanistic) than for Group ES.

Most pointed, is that mean differences between acute and chronic duration are sharpest for Group LM. Indeed, this group, in the *chronic* condition, has the lowest (most linear) score. To explain this result, one might conjecture from a theoretical perspective, that both the *passage of time* and the focus on *personality deficits* are very present in the chronically-focused vignettes, and that these two themes would be inherently recognized by the more linear-mechanistic clinicians.

On the other hand, an *acute* situation would tend to involve less the passage of time, and less in the way of personality deficits. It would, instead, likely carry with it more in the way of *current circumstances*. This would fit far more outstandingly with the ecological-systems bent of Group ES than with the LM subjects for whom current circumstances do not hold inherent prominence.

We may conjecture that with acute duration-severity, LM clinicians may not be able to fall back on personality deficits and

historical emphasis, and may therefore be more inclined to relate to the environmental and social factors which stand out.

Table 6

Differential mean scores for duration x group: Assessment

Duration x Group			Mean
Acute	x	LM	2.35
Acute	x	M	2.28
Acute	x	ES	1.90
Chronic	x	LM	1.21
Chronic	x	M	1.27
Chronic	x	ES	1.40

The factor judge neither obtained significance, nor interacted significantly with any remaining factors. Hence, in our analysis of assessment scores, we may disregard the effect of the factor judge.

In contrast, the measure of duration-severity obtained significance. In Table 7, the acute condition ($\bar{M} = 2.17$) received higher (ecological-systems-weighted) scores than the chronic condition ($\bar{M} = 1.29$), whose scores were weighted toward the lower (linear-mechanistic) end of the spectrum.

(It should be noted, henceforth, that for visual space in tables, and a less cumbersome text, our three independent variables will often be referred to as "Group" (clinical-orientation group), "Duration" (duration-severity), and "Context" (interpersonal-context)).

Table 7

Differential mean scores for duration: Assessment

<u>Duration</u>	<u>Mean</u>
Acute	2.17
Chronic	1.29

A statistically significant difference emerges in the analysis of variance for interpersonal-context. As illustrated in Table 8, the isolated condition induced lower (more linear-mechanistically-weighted) scores than the involved condition (whose scores reflected an ecological-systems weighting).

Table 8

Differential mean scores for context: Assessment

<u>Context</u>	<u>Mean</u>
Isolated	1.53
Involved	1.94

Table 9, shows the interaction between duration-severity and interpersonal-context.

Table 9

Differential mean scores for duration x context: Assessment

<u>Duration x context</u>	<u>Mean</u>
Acute-isolated	2.10
Acute-involved	2.25
Chronic-isolated	.97
Chronic-involved	1.62

A review of Tables 7,8 and 9 shows that chronic duration generates lower (more linear) scores than acute duration. Furthermore, the isolated context produces lower means than the involved one. It is, however, only in combination with chronic duration that the isolated context stands out from the involved one by a difference (.65) which is four times greater than the difference under the acute condition (.16). Thus, while chronic duration generates lower (linear-mechanistic) scores, the chronic-isolated condition generates the lowest (most linear) scores. While the acute-involved condition generates the highest (most ecosystems) mean, it is set apart less dramatically from the means of the other conditions than the chronic-isolated condition is set apart from the other scores.

Analysis of Variance for Intervention: Open-Ended Questions.

The results of a four-way ANOVA (group x duration x context x judge), for intervention data, are presented in Table 10.

Table 10

Four-way analysis of variance for open-ended intervention responses

Source	Sum of squares	Degrees of freedom	Mean square	F
Judge	2.66	2	1.33	5.85**
Judge x Group	0.56	4	0.14	0.61
Error	24.97	110	0.23	
Duration	11.55	1	11.55	7.62**
Duration x Group	1.27	2	0.64	0.42
Error	83.43	55	1.52	
Context	30.00	1	30.00	18.54**
Context x Group	0.55	2	0.28	0.17
Error	88.99	55	1.62	
Group	7.04	2	3.52	1.58
Error	122.28	55	2.22	
Duration x Context	1.58	1	1.58	1.10
D'tion x C'text x Grp	0.04	2	0.02	0.02
Error	78.81	55	1.43	
Duration x Judge	0.65	2	0.32	1.26
D'tion x Judge X Grp	4.17	4	1.04	4.06**
Error	28.28	110	0.26	
Context x Judge	3.25	2	1.63	5.86**
C'text x Judge x Grp	0.71	4	0.18	0.64
Error	30.57	110	0.28	
D'tion x C'text x Judge	2.33	2	1.16	5.04**
D'tion x C'text x Judge X Group	1.03	4	0.26	1.12
Error	25.41	110	0.23	

** $p \leq .01$

Group (or Grp) = clinical-orientation group

Duration (or D'tion) = duration-severity

Context (or C'text) = interpersonal-context

There is indeed a main effect for the factor judge. Moreover, this factor interacts significantly in three particular combinations with other factors, which will be addressed subsequently.

Table 11 illustrates differential scores among the three raters.

Table 11

Differential mean scores for judge: Intervention

Judge	Mean
Judge-1	2.13
Judge-2	2.20
Judge-3	2.28

Our findings show Judge-1 to be more linear-mechanistic in score, Judge-2 to be mid-range, and Judge-3 to be more ecological-systems.

A glance at Tables 12, 13 and 14 shows that there are statistically significant findings for each judge, separately with respect to the factors duration-severity and interpersonal-context. Therefore, our use of judges' combined scores did *not* mask true effects for these two factors. Thus, we may, indeed, utilize combined scores in our data analysis of these two factors.

Table 12

Analysis of variance for open-ended intervention responses: Judge-1

Source	Sum of squares	Degrees of freedom	Mean Square	F
Duration	2.08	1	2.08	4.13*
Duration x Group	2.54	2	1.27	1.91
Error	38.48	58	0.66	
Context	16.75	1	16.75	24.79**
Context x Group	0.02	2	0.01	0.02
Error	39.19	58	0.68	
Group	1.85	2	0.93	1.25
Error	42.84	58	0.74	
Duration x Context	0.01	1	0.01	0.03
D'tion x C'text x Grp	0.10	2	0.05	0.09
Error	32.88	58	0.57	

* $p \leq .05$; ** $p \leq .01$

Table 13

Analysis of variance for open-ended intervention responses: Judge-2

Source	Sum of squares	Degrees of freedom	Mean square	F
Duration	3.09	1	3.09	5.48*
Duration x Group	2.07	2	1.04	1.84
Error	32.69	56	0.56	
Context	16.20	1	16.20	27.37**
Context x Group	0.15	2	0.08	0.13
Error	34.33	56	0.59	
Group	3.59	2	1.80	2.44
Error	42.65	56	0.74	
Duration x Context	0.04	1	0.04	0.06
D'tion x C'text x Grp	0.18	2	0.09	0.15
Error	34.54	56	0.60	

* $p \leq .05$; ** $p \leq .01$

Table 14

Analysis of variance for open-ended intervention responses: Judge-3

Source	Sum of squares	Degrees of freedom	Mean square	F
Duration	5.88	1	5.88	7.51**
Duration x Group	2.10	2	1.05	1.34
Error	43.85	56	0.78	
Context	3.48	1	3.48	4.72*
Context x Group	0.80	2	0.40	0.43
Error	52.38	56	0.94	
Group	1.64	2	0.82	0.69
Error	66.09	56	1.18	
Duration x Context	4.62	1	4.62	6.32*
D'tion x C'text x Grp	0.23	2	0.11	0.16
Error	40.91	56	0.73	

* $p \leq .05$; ** $p \leq .01$

As main effects, there are statistically significant differences for both duration-severity and interpersonal-context for all three judges. The interaction between duration and context, however, appears only for Judge-3. The most parsimonious explanation for this difference would be a sampling vagary for an unreliable Judge-3. who repeatedly appears as a maverick.

In Table 15, we see that vignettes with acute duration-severity received higher (ecosystems-oriented) scores ($\underline{M} = 2.30$) than vignettes with chronic duration-severity. The latter received significantly lower (linear-mechanistically-weighted) scores ($\underline{M} = 2.11$).

Table 15

Differential mean scores for duration: Intervention

Duration	Mean
Acute	2.30
Chronic	2.11

When we look at the trend for interpersonal-context in Table 16, we see that the isolated condition has lower (more linear-mechanistic) scores than the involved condition, whose scores are higher.

Table 16

Differential mean scores for context: Intervention

Context	Mean
Isolated	2.05
Involved	2.41

In summation, one sees two general trends for both *open-ended assessment and intervention scores*. First, chronic duration-severity tends to have a greater effect in generating lower (more linear-mechanistic) means than acute duration-severity. Second, the isolated interpersonal-context tends to produce the lowest (most linear-mechanistic) scores for both assessment and intervention responses.

Finally, for *open-ended assessment scores*, the factor group interacts with duration-severity such that for open-ended assessment, the chronic condition seems to effect a linear interpretation. On the one hand, it operates as a main effect such that the chronic condition generally contributes to a linear interpretation. On the other hand, the chronic condition interacts with the isolated interpersonal-context such that clients who are seen as chronic *and* isolated tend to be seen as most linear, while the "chronic" clients are perceived particularly by the linear-mechanistic group of clinicians in a linear fashion.

Instrument-2, Forced-Choice Questions: General Statement.

Both analysis of variance and chi-square analyses were performed on the forced-choice responses of Instrument-2. The rationale for both types of data analysis is as follows:

The binary forced-choices for each response may be seen as representing the two ends of a *continuum*, for which mid-range and mixed gradations exist, but are not offered as choices, in order to

force sharp differences for scoring purposes. Nevertheless, with continuous data, analysis of variance would be utilized.

If, however, we were to consider response alternatives to represent discrete and dichotomous choices, then cross-tabulation analysis of these two factors, and of their interaction, could not directly be addressed (Winer, 1971, p. 284), and chi-square analysis would indeed be our alternative. In planning our data analysis, it seemed to be of potential interest and value to consider the notion of discrete data, and perform chi-square analyses, to see what might emerge. It was in this spirit that chi-square analyses were performed, separately for the five assessment and the nine intervention items, in a 3 x 2 (group x response) matrix. Responses were first assessed with regard to clinical-orientation of subjects for the four combinations of acute/chronic and involved/isolated conditions.

Analysis of Variance for Assessment: Forced-Choice Questions.

A four-way analysis of variance was done for the factors (a) clinical-orientation group, (b) duration-severity, (c) interpersonal-context and (d) their interactive effects.

As illustrated in Table 17, the two factors which showed statistical significance are *clinical-orientation group* (primary independent variable), and *duration-severity* (a secondary independent variable). There was no statistical significance for interpersonal-context.

Table 17

Four-way analysis of variance: Forced-choice assessment responses

<u>Source</u>	<u>Sum of squares</u>	<u>Degrees of freedom</u>	<u>Mean square</u>	<u>F</u>
Group	41.52	2	20.76	5.54**
Error	224.90	60	3.75	
Duration	46.29	1	46.29	30.22**
Duration x Group	5.81	2	2.90	1.90
Error	91.90	60	1.53	
Context	0.14	1	0.14	0.14
Context x Group	2.38	2	1.19	1.18
Error	60.48	60	1.01	
Duration x Context	1.92	1	1.92	2.22
D'tion x C'text x Grp	0.13	2	0.06	0.07
Error	51.95	60	0.87	

** $p \leq .01$

Group (or grp) = clinical-orientation group

Duration (or D'tion) = duration-severity

Context (or C'text) = interpersonal-context

Data in Table 18 support Hypothesis-1, that there are statistically significant positive correlations between clinical-orientation groups to which clinicians belong, and their assessments, as scored on Instrument-2. The mean for Group LM is lowest (most linear) The ES group presents the highest mean. The mean score for the middle (M) group is technically in the middle, but is clearly very close to the LM group mean.

Table 18

Differential mean scores for group: Assessment forced-choice responses

<u>Group</u>	<u>Mean</u>
LM	2.43
M	2.44
ES	3.25

Table 19 illustrates support for hypothesis 2a, that there are statistically significant positive correlations between duration-severity and the kinds of assessments which are formulated by clinicians. Chronic duration-severity clearly produces lower (more linear-mechanistic) scores. Inversely, the acute condition responses produce higher (more ecosystems) scores. (While these results represent forced-choice assessment data, they were previously shown to be true for our open-ended assessment data as well).

Table 19

Differential mean scores for duration-severity: Assessment forced-choice responses

<u>Duration</u>	<u>Mean</u>
Acute	3.05
Chronic	2.39

Since there are no statistically significant results for social-context, there is no support for hypothesis 3a, which deals with the correlations between interpersonal-context and clinicians' assessments.

Chi-Square Analysis for Assessment: Forced-Choice Questions.

Chi-square scores represent indices which compare response-frequencies of Groups LM, M and ES. This means the frequency with which subjects from each group differ by choosing either a linear type response or an ecological type response. Statistical significance of a score indicates that the frequency distributions of these choices among our three subject-groups are statistically unlikely to be so different unless particular factors influence these differences. These factors would be one or more of our independent variables.

Because chi-square data for forced-choice assessment responses did not produce much in the way of statistically significant findings, chi-square frequency-distribution tables were omitted. A perusal of these tables, however, reveals a definite and almost fully consistent trend on an item-by-item basis. Clinicians in Group LM have a larger proportion of linear-mechanistic choices than ES clinicians have. while clinicians in Group ES show a larger proportion of ecological-systems choices than do LM clinicians. This trend supports hypothesis-1a.

There is, however, one repeatedly statistically significant result from our chi-square data. Operationalized assessment criterion #1 (forced-choice Item 3 on Instrument-2), which represents "unilateral assessments *versus* mutuality through contracting", is the only operationalized assessment criterion which demonstrates statistical significance under three out of four conditions of duration-severity combined with interpersonal-context. The three conditions are acute-involved ($\chi^2=6.20$), chronic-isolated ($\chi^2=9.72$) and chronic-involved ($\chi^2=10.31$). All are significant to at least the level of $p \leq .05$. Of note is the observation that while the acute-isolated condition does not produce a chi-square value which is of statistical significance, it too presents data whose values support hypothesis-1: The LM group has a larger proportion of linear responses than the ecological group, while the ES group presents a larger proportion of ecological responses than the linear group.

Thus, we are presented with a rather regular trend in chi-square frequency-distributions which reveals operationalized assessment criterion #1 (forced-choice Item 3) as demonstrating frequency-distributions which show statistical significance more regularly than any other item. We may indeed infer that the comparative vignette criteria for this item of "unilateral assessment" *versus* "mutuality through contracting" have more than chance influence on the clinical judgments of our subjects.

Analysis of Variance for Intervention: Forced-Choice Questions.

A four-way analysis of variance was done for the factors clinical-orientation group, duration-severity, interpersonal-context, and their interactive effects

As illustrated in Table 20, the only factor which obtained statistical significance is group. This result lends support to hypothesis 1-b that differences exist in intervention formulations, according to group.

Table 20

Four-way analysis of variance: Forced-choice intervention responses

<u>Source</u>	<u>Sum of squares</u>	<u>Degrees of freedom</u>	<u>Mean square</u>	<u>F</u>
Group	38.38	2	19.19	3.46*
Error	332.55	60	5.54	
Duration	.06	1	.02	.02
Duration x Group	3.56	2	1.78	.47
Error	226.88	60	3.78	
Context	5.73	1	5.73	3.50
Context x Group	9.56	2	4.78	2.92
Error	98.21	60	1.64	
Duration x Context	6.35	1	6.35	2.59
D'tion x C'text x Grp	7.84	2	3.92	1.60
Error	147.31	60	2.46	

* $p \leq .05$

Group (or grp) = clinical-orientation group

Duration (or D'tion) = duration-severity

Context (or C'text) = interpersonal-context

As in analysis of variance of forced-choice assessment data, the factor group showed statistical significance. (Unlike the situation with assessment data, however, there was no statistical significance for duration-severity.)

Data in Table 21 which follows, illustrates support for hypothesis-1b, that there are statistically significant positive correlations between clinical-orientation groups to which clinicians belong, and their intervention plans, as scored on Instrument-2. As with assessment scores, the mean for Group LM is lowest (most linear). The ES group presents the highest mean. The mean score for the middle (M) group, again, is technically in the middle, but is clearly very close to the LM group mean.

Table 21

Differential mean scores for group according to vignette condition:
Forced-choice intervention responses

<u>Group</u>	<u>Mean</u>
LM	2.50
M	2.51
ES	2.92

Chi-Square Analysis for Intervention: Forced-Choice Questions.

As was the case with assessment data, chi-square data for forced-choice intervention responses did not produce much in the way of statistically significant findings. Therefore, chi-square frequency-distribution tables were omitted. These tables, however, reveal some trends in more than half our intervention items. Namely, clinicians in Group LM have a larger proportion of linear-mechanistic choices than ES clinicians, while clinicians in Group ES show a larger proportion of ecological-systems choices than LM clinicians. The trends for intervention data, however, are less consistent and therefore more qualified than the assessment trends, and therefore cannot clearly be said to support hypothesis-1b.

There is, however, one repeatedly statistically significant result from our chi-square data. Operationalized intervention criterion #5 (forced-choice Item 12, on Instrument-2), which represents "emphasis on office/agency interventions *versus* varied life locations for interventions" is the only operationalized intervention criterion which demonstrates statistical significance in three out of four conditions of duration-severity combined with interpersonal-context. These three conditions are: acute-involved ($\chi^2=13.33$), chronic-isolated ($\chi^2=13.24$), and chronic-involved ($\chi^2=6.71$). All are statistically significant at the level of $p \leq .05$, at minimum. Of note is the observation that while the acute-isolated condition does not produce a chi-square value which is of

statistical significance, it nevertheless presents data whose values support hypothesis-1b: The LM group has a larger proportion of linear-mechanistic responses than the ES group has; while the ES group presents a larger proportion of ecological-systems responses than the LM group presents.

Thus, we are presented with a rather regular trend in chi-square frequency-distributions which reveals Operationalized Intervention Criterion #5 (forced-choice Item 12) as demonstrating frequency-distributions which show statistical significance more regularly than any other item. We may indeed infer that the comparative vignette criteria for this item of "emphasis on office/agency interventions *versus* varied life locations for interventions" have more than chance influence on the clinical judgments of our subjects.

Trend for the Four Vignette Conditions.

The combination of the factors duration-severity with interpersonal-context attains statistical significance only in the analysis of variance for *open-ended assessment data*. A constant trend is, nonetheless, visible when we examine this combination for our *open-ended intervention data*, for *forced-choice assessment data* and for *forced-choice intervention data*. Table 22, below, demonstrates this trend. In four sets of conditions, the *chronic-isolated* condition produces lower (more linear-mechanistic) scores than the other three conditions. This is a testament to the power

of the chronic-isolated condition to generate responses in our clinicians which reflect a linear-mechanistic orientation. There is no clear counterpart for any other condition to uniformly generate highest (most ecosystems) scores on all four sets of data. Table 22 follows.

Table 22

Summary of open-ended and forced-choice means for the four combinations of duration-severity and interpersonal-context of the four vignette presentations

Condition	<u>Open-ended</u>		<u>Forced-choice</u>	
	Assess***	Interv**	Assess*	Interv*
Chronic-isolated	0.97	1.83	2.26	2.47
Chronic-involved	1.62	2.37	2.46	2.76
Acute-isolated	2.10	2.14	3.13	2.67
Acute-involved	2.25	2.46	2.97	2.63

*** Statistically significant for at least two judges.

** Trend; statistically significant for one judge.

* Trend

Assess = assessment data. Interv = intervention data.

CHAPTER VI

Discussion

Introduction to Findings.

Principle findings. The findings of this study will be related to its hypotheses, by beginning with a look at Table 23, below, which summarizes the data from the analyses of variance with reference to the hypotheses.

Three criteria will be utilized to determine the relevance of various data.

1. Whether or not particular data shows *statistical significance* as opposed to presenting a *trend*, bears on its relevance.

2. Whether or not a particular finding *transcends both methods of data collection (open-ended and forced-choice)*, as opposed to its being *limited to one method of data collection*.

3. Whether or not a finding is a *main effect* of one independent variable, as opposed to its being an *interactive effect* between two (or more) independent variables.

Additional findings. Two specific chi-square findings will be discussed with reference to comparative operationalized criteria which distinguish between linear and ecological aspects of practice.

Table 23

Summary of findings for each independent variable condition,
according to type of data and method of data collection

Condition	Assessment		Intervention	
	Open-ended	Forced-choice	Open-ended	Forced-choice
<u>Main effects:</u>				
Hypothesis-1:				
Clin-orient'n: LM Group	---	* more linear	---	* more linear
ES Group	---	more ecolog	---	more ecolog
Hypothesis-2:				
Duration-severity: Acute	* more ecolog	* more ecolog	* more ecolog	---
Chronic	more linear	more linear	more linear	---
Hypothesis-3:				
Intpers.-context: Isolated	* more linear	---	* more linear	---
Involved	more ecolog	---	more ecolog	---
<u>Interactions:</u>				
Group x Duration:				
LM Grp x Chronic	* most linear	---	---	---
Context x Duration:				
Isola. x Chronic	* most linear	+ most linear	+ most linear	+ most linear
* Statistically significant. + Trend, not significant.				

Type of Data: Assessment and Intervention Data.

We note that findings for assessment data tend to be stronger than those for intervention data.

Intervention data show only three significant findings for main effect, and none for interactions.

Assessment data demonstrate four significant findings for main effect and two additional ones for interactive effects.

Hypotheses-1a and -1b: On clinical-Orientation Group.

Hypotheses-1a and -1b are supported by statistically significant *forced-choice* data. The findings are in the correct direction: For both assessment and intervention data, significantly lower (more linear) scores are generated by Group LM, and significantly higher (more ecological) scores are generated by Group ES.

There is also a fair amount of support for hypothesis-1a, on assessment, in the interaction of the the factors group and duration, for our *open-ended* data. This finding is in the correct direction: The LM group generates the lowest (most linear-mechanistic) judgments for assessment of the chronic problem/situations.

Thus, we observe that support for hypothesis-1a, on assessment, derives from both methods of data collection. It derives from forced-choice data, where it emerges as a main effect, as well as from open-ended data, where it comes out as an interactive effect. Hypothesis-1b, on intervention, however, is

supported only by data which emerge from the forced-choice method of data collection.

It is interesting to ponder why the statistically significant main effects which support hypotheses-1a and -1b come from forced-choice data:

We note that clinicians responded to the differences in conditions of the four vignettes which they read. These clinician-subjects, themselves, were unaware of the group differences which had previously been generated in this research. This experimenter, on the other hand, was of course aware of differences both in vignette conditions and in clinical-orientation group membership.

When clinicians responded to the open-ended questions about vignettes, they were inherently required to think in their own language, to pay more attention to what they had actually read in each vignette, and to *formulate* their own ideas, so as to be able to write an assessment or an intervention plan. They, themselves, had to be sensitive to the conditions of each vignette.

The forced-choice items of Instrument-2, however, give preformulated statements which are couched in rather formal, conceptual, theoretical language. The questions in Instrument-1 were indeed couched in this more formal, conceptual-type language, as well. In retrospect, one might think of the forced-choice questions, to some extent, as repetitions of the kind of material which had already been utilized for inquiry in Instrument-1, except that a vignette intervened, which could

indeed change the response. Unlike the graded multiple-choices which were offered in Instrument-1, however, there was no room for thought-through complexities among forced-choice response options. Therefore, it is not surprising that the forced-choice response measures ended up being more sensitive to distinctions for the variable clinical-orientation group, given that the parameters from which these measures derive clearly distinguish group differences.

It would therefore be equally unsurprising that the more freewheeling style of the open-ended responses lends itself to greater sensitivity to the factors duration-severity and interpersonal-context, in light of the fact that judges were trained to notice these variables.

Hypotheses-2a and -2b: On Duration-Severity.

The findings for duration-severity cut across both open-ended and forced-choice methods of data collection.

There are five findings, (three for main effects, and two for interactive effects,) and they are in the correct direction: Significantly lower (more linear) scores are generated by the chronic condition, while significantly higher (more ecological) scores are generated by the acute condition.

The only partial exception is for the interaction of group with duration. While it is clear that the lowest (most linear) score is generated for the interaction of the LM group with the

chronic factor, the picture presented by the interaction of the acute factor with the ES group is not a clear inverse of that finding. The reasons for this discrepancy are not clear.

With regard to support for hypothesis-2a, on assessment, by the interactive effect of duration together with context, the chronicisolated problem/situation, for open-ended data, generates by far the lowest (most linear) scores, while the acute-involved interaction produces the highest (most ecological) scores.

It is striking, however, among our five findings for duration-severity, that for hypothesis-2a, on assessment, there are two statistically significant main effects (one for open-ended and one for forced-choice data), and also two statistically significant interactive effects for our open-ended data. There is only *one* statistically significant finding for duration-severity for intervention data; it is a main effect for open-ended data.

Hypotheses-3a and -3b: On Interpersonal-Context.

Statistically significant results for our hypotheses on interpersonal-context are limited to the open-ended method of data collection. There is less support for these hypotheses, because they do not transcend both methods of data collection.

Specifically, hypothesis-3a, on assessment, is supported by one main effect and one interactive effect (with duration). Support for hypothesis-3b, on intervention, is limited to one main effect.

With reference to support for both hypotheses by a main effect, significantly lower (more linear) scores are generated by the isolated condition, and significantly higher (more ecological) scores are generated by the involved condition, for both assessment and intervention data.

With regard to support for hypothesis-3a, on assessment, by the interactive effect of context with duration, the chronic-isolated problem/situation, for data which are collected by the open-ended method, generates by far the lowest (most linear) scores for the chronic-isolated interaction and the highest (most ecological) scores for the acute involved condition.

Interactive Effects.

The interactive effects of group with duration, and context with duration have been discussed with reference to the support which they lend to particular hypotheses.

There is, however, a particular situation for the chronic-isolated condition of the interaction of context with duration. The chronic-isolated condition presents the lowest (most linear) assessment *and* intervention scores for both open-ended and forced-choice data. While this finding is at a statistically *significant* level only for open-ended assessment data, it is also a marked *trend* for forced-choice assessment data, and for open-ended and forced-choice intervention data. As a trend, it transcends both methods of data collection. It holds up for intervention scores (although not quite as strongly) as well as for assessment scores.

It is noteworthy that the "theoretically inverse" problem/situation, the acute-involved condition, does not stand out boldly across the board, so to speak, under both methods of data collection, and for both assessment and intervention plans.

Duration-Severity and Interpersonal-Context as Interactive and Main Effects: Commentary and Speculation.

It is really quite interesting to speculate about why statistically significant findings for duration-severity and interpersonal-context emerge from *all* our open-ended data. (This is particularly interesting because open-ended data were not a source of statistically significant findings for our clinical-orientation hypotheses.) What stands out is that our four vignettes may indeed be thought of as a *series*, which is the way in which they were presented to our subjects. Because the problem/situations described in the four vignettes are all so strikingly different from one another, one would expect that clinicians could not help but observe and react to these differences. (By way of contrast, a clinician might not so readily observe his own clinical-orientation, especially if he is not seasoned in and secure in its use.) Clearly, the free-handed openended format allows for such reactive responses, while the forcedchoice format would appear not to do so.

What is not clear is an explanation about the limitation of statistically significant interpersonal-context findings to open-ended data only, while duration-severity produced significant

findings across both types of data. We may, therefore, simply observe that the open-ended response format allows differences in interpersonal-context to be distinguished more readily than does the forced-choice format.

We may draw some conclusions about results for the two secondary independent variables. *Chronic* duration-severity, *in combination with an isolated* interpersonal-context, most consistently produces lower (most linear-mechanistic), statistically-significant responses. We have conjectured that chronicity, because it inherently involves a timeline view of a case, may lend itself more readily to the application of linear-mechanistic principles, which take place over time. These include linear causality, drive reduction, and regression and entropy. We might also conjecture that the chronicity seen by the clinician might readily lend itself to thinking along lines of personality deficit and psychopathology, which from a linear-mechanistic orientation require time to develop and "set in," so to speak. Such a view might also signify an intrapsychically-oriented focus of mind-body dualism.

An *acute* situation, on the other hand, would be more immediate and not related to an extended time period. It would therefore not present an "unfriendly" context for the application of ecological-systems principles which would seem to lend themselves more readily to being applied to more acute, immediate, situations.

These principles would especially include equifinality, organismic quality and heterostasis.

There seems to be a tendency in our interpersonal-context variable, for the *isolated* condition to induce lower (more linear-mechanistic) scores than the involved condition. Although this tendency does not demonstrate the strength which is shown by chronic duration-severity, it is sufficiently present to be worthy of an attempt at explanation. It would appear that an isolated client would present a simpler, more easily analyzable picture which would appear to lack the environmental richness of an involved client. Focus, for a clinician, on one client might *lend* itself more readily to intrapsychic analysis and thereby fit with a notion of mind-body dualism. Also, a more isolated person-in-situation might more readily accommodate the notion of intervention in isolation from any interpersonal-environmental life-context.

By contrast, the *involved* interpersonal-context would tend to present factors which could be more readily seen from the vantage-points of equifinality, organismic quality and heterostasis. There would be *no inherent ease* in employing interventions in isolation from the life context of the person(s) in the easily viewable interpersonal-environmental context.

Additionally, the lack of experience of student clinicians may make them rather vulnerable to the pull of situational variables, despite their stated adherence to a particular theoretical clinical-orientation.

Additional Findings: Comparative Operationalized Criteria for
Assessment and Intervention Plans.

Among forced-choice assessment items, only *operationalized assessment criterion #1* (assessment item-3 on Instrument-2), which refers to unilateral assessment *versus* mutuality through contracting, was supported in a statistically significant manner by chisquare data. The implications for this would appear to lie in the degree of client involvement by clinicians as they go through an assessment. Clearly, if ES clinicians mutually involve clients more fully than LM clinicians do, in the assessment process, we might expect major effects on the outcomes of interventions. The implications, however, would appear to reflect on the adherence (or lack thereof) to a basic principle of social work practice about the importance of client involvement in the helping process. Traditionally, this would include understanding as well as intervening. Gordon Hamilton, whose person-in-situation formulation would fall into a broadened clinical-normative, but nevertheless, linear-mechanistic framework, reflected that "help is most effective if the individual participates actively and responsibly in the helping process" (Hamilton, 1951, 13). A lack of client involvement in the processes of understanding and planning raises a serious question about the degree to which linear-mechanistically-oriented clinicians (explicitly or implicitly) miss opportunities to engage the client to the fullest extent possible. Such a discrepancy has a bearing on social work

education, in the need for a watchful emphasis on teaching the application of the principle of client involvement by also teaching about pitfalls where clinicians might inadvertently be blind to this principle.

Among forced-choice intervention items, only *operationalized criterion #5* (intervention item-12 in Instrument-2) was supported by statistically significant chi-square findings. This item refers to office/agency interventions *versus* interventions at varied life locations. There are implications here for both practice and education in the exploration of the effects of meeting with clients, either within or apart from the varied physical locations of clients' lives and relationships. The types of situations and the kinds of client need which lend themselves more specifically to one or the other type of intervention, are clearly useful as knowledge for both practice and research. Measures of both client and clinician experience, might also be interesting avenues for future research.

Some Conclusions.

In conclusion, about our hypotheses, we may say that from a clinician's theoretical-philosophical orientation-perspective as measured by Instrument-1, some predictions may reasonably be formulated regarding assessment, but not so reasonably with regard to intervention plans. Hence, there seems to be a dissociation between assessment and intervention plans.

One possible explanation for this dissociation may be that assessment may be more directly related to (and easier to extrapolate from) one's theoretical orientation than one's intervention plans. Thus, it may be that what one does about a situation clinically may not necessarily be closely related to how one sees the problem. Research into dependence or independence between a clinical assessment, and what clinicians actually do that is ostensibly based on such assessment, would be of great interest here. We may conjecture, therefore, that while in the practice literature, the assessment and intervention processes have an important relationship to one another, they may actually involve *different* kinds of cognitive processes which may have as much, or more, bearing on clinical choices, than the ostensible traditional practice relationship between assessment and ensuing intervention plans. This, however, remains conjecture for purposes of our discussion, as this study does not purport to delve into the psychological or physiological issues behind cognition.

Comparison of Results.

It is difficult to make comparisons of this study with others, as we know of no other studies which undertake this particular research in which clinical judgments of case material is compared to practice-orientations, notably with reference to the two approaches researched in this study.

Ecological Validity.

Ecological validity is a research term (which is *not* directly related to the ecological metaphor utilized in this study). It refers to the question of how much can be validly generalized from specific details of the laboratory study to the general conditions of the natural world.

We may conjecture that the open-ended method of data collection is closer to what a clinician really does in the actual work, and might therefore have more ecological validity than the forced-choice method of data collection. The latter, which deals with the extremes of a construct, would seem to be removed from the subtleties of a clinician's day-to-day work.

It is therefore rather discomfiting that the main effect for clinical-orientation groups did not transfer to our open-ended data.

On the Use of Students as Subjects.

Experienced clinicians, if utilized as subjects, might have been chosen on the basis of criteria which reflect a *depth of conviction* about principles which underlie a practice-orientation, a depth of conviction which second-year students could not possess. Such depth of belief would contribute to reliability. Additionally, experience and concomitant degree of comfort and confidence with assessment and intervention planning, within one's self-perceived practice-orientation might contribute to the likelihood of high

reliability of assessment and intervention plan responses. The prohibitive cost in time and money to locate a pool of such available clinicians from which to choose the LM, M and ES groups for this design precluded this route as a viable option.

The use of students as subjects was facilitated by the cooperation of fourteen CSWE-approved graduate schools in the United States and Canada which placed no restrictions on the availability of lists which comprised a pool of over 1,000 students for participation in this study. From this pool of potential subjects, over 650 willing students met basic eligibility criteria from which the researcher could choose 200 who most closely met specific selection criteria which were geared to balancing subject characteristics and maximizing variance of responses.

There were some clear limitations to use of the student pool. Students' clinical experience and training were minimal (although among those chosen for the group of 200, many did have prior experience and/or degrees in related fields).

Given their newness to the field, the reliability over time of subjects' self-perceived adherence to principles of a particular school of thought, might be questioned. Because, however, Instrument-2 vignettes and the questionnaires about assessment and intervention plans were administered within weeks of Instrument-1 completion, the likelihood of change in beliefs over such a brief period would seem to have been minimized.

While students with the *most* extreme Instrument-1 scores were grouped into the LM and ES scores, the *depth and conviction* of belief in principles of a particular practice orientation might generally be far less for students than for experienced clinicians. Experienced clinicians who are clear about the way they see their practice orientation might be seen to have gleaned a set of internalized beliefs about practice based on years of professional experience, and perhaps additional training as well.

Minimal experience might also render student assessments and intervention plans less reliable. One might expect that the more clinical experience a clinician has had, the greater the reliability (and perhaps ecological validity, as previously defined) of that clinician's clinical judgments).

Observations and Conjecture about a Design Alternative to Enable the Use of Experienced Clinician-Subjects.

The design and format used in this study for data analysis is, in its traditional search to determine certainty, reflective of a linear view of epistemology. A design which were based on in-depth descriptive interviews, and focused more on description and subjective interpretation of the interrelationship of data, as opposed to efforts to determine certainty of results, might have been more in line with an ecological approach to epistemology. Such an alternate design would have traded off, so to speak, large amounts of data from many clinicians to be statistically

analyzed, for detailed, descriptively-oriented, in-depth data, to be interpreted from varied viewpoints such as those of the clinicians and the clients being worked with. The use of a small number of (more expensive) highly experienced clinician-subjects, might have been a cost-effective trade-off to the large number of (minimally-remunerated) student-subjects. Such a saving in time and money might have rendered feasible the engagement of some form of "live" case material as opposed to "constructed" vignettes. The use of mailed, situational vignettes, while viable for reasons of uniformity and practicality, does not present a clinician with the client affect and the opportunity for client-worker involvement which have a bearing in the real clinical situation. Such a design and format, for data collection and results interpretation, might have been more in line with an ecological view of epistemology.

Implications for Social Work Education.

Group differences. Clearly, it is of value for social work educators to teach differences between our two approaches. It could be useful for the educator to keep in mind that *theoretical* differences, which show up more readily in our forced-choice responses, may be easier for students to understand and deal with than the *actual* differences in live practice situations, where issues must be identified from the case material as it emerges in process.

The use of Instrument-1, or a revision of it (some suggestions for which are explored later in this chapter), could be an excellent self-observational tool which would enable students (as well as advanced clinicians) to look objectively at, and thereby think carefully about their explicit (and hidden) orientations to practice, in ways which they may not have previously conceived. It could indeed be utilized as an adjunct in the teaching of theory which may then be compared to one's own, possibly idiosyncratic, notions about the components of a particular clinical-orientation.

Secondary independent variables. The chronic-isolated client problem/situations tend to pull the clinician's judgments away from the ecological approach. In their learning the ecological approach, students need to be made aware that the very use of that approach may be inherently more difficult with a client who demonstrates chronic and isolated circumstances.

By the same token, the acute-involved client problem/situation might be a rather useful starting point for from which students might effectively learn ecological principles in practice, and *then* move toward the more problematic area of applying these principles in practice situations which provide an inherent linear pull. It could indeed be a significant learning experience for students to apply principles they have learned about the ecological approach in the face of problem/situations which do not easily lend themselves to the application of that approach.

Furthermore, our results point toward a problem in the application of one's view of practice in an open-ended way, which is the way in which clinicians work in their day-to-day practice. It would appear, from our findings, that students may abandon their theoretical conceptions when faced with specific material from an actual case. This would make it all the more important in graduate education for attention to be paid to the learning process of the actual application of practice concepts in the open-ended, true-to life, format. Thus, while students may be working with open eyes if they "say it as they see it" so to speak, it may be that they do not see *how* to apply what they have learned conceptually, or that they do not see its *relevance* in specific practice situations, especially those which tend toward the more chronic-isolated problem/situations.

The implications for emphasis on first year as opposed to second year curriculum, as well as for requirements which are placed on field instruction agencies to provide specific types of experiences to students, might be looked at fruitfully in light of our findings. Specifically, it would seem important to arrange for students first to be made aware of, and then to deal with the expected difficulties inherent in distinguishing and applying the ecological approach in the face of chronic-isolated problem/situations.

Implications for Further Research.

It would be useful to social work education and to clinical knowledge in general to determine if the same type and direction of results would emerge from the testing of experienced clinicians. The latter would likely have their clinical-orientation beliefs, and their assessment and intervention judgments based on a firmer, more solid sense of knowledge born of experience and learning. Thus, a seasoned clinician who belongs to the ES group, by virtue of beliefs about practice, might be more likely to produce clear, ecologically oriented assessments and intervention judgements, especially in the problematic area of the chronic-isolated condition. In fact, such a finding would empirically substantiate the usability of ecosystems thinking under most-difficult-to-use conditions. In addition, if seasoned clinicians were to generate open-ended statistically significant results, we would have some highly useful information about the use of both the ecological and linear approaches, *and* about differences between capabilities of more seasoned, as opposed to new, clinicians. One conjecture might be that students, whose practice orientation falls in the province of an ecosystems perspective, may not yet have the necessary world-view and vocabulary to utilize this approach in practice, notably when faced with the pull of a chronic-isolated client.

It is not in the province of this dissertation to pass judgment on which approach is more helpful to clients. It might,

in fact be a useful hypothesis for future research to inquire about each approach under varied conditions of client problem/situation (such as those presented in this research), and under varied conditions of practice. (Conditions of practice to explore could be those which specifically achieved statistical significance as aspects of assessment and intervention plans in Instrument-2--namely, "unilateral assessment" *versus* "mutuality by contracting to define the problem/situation," and "intervention in agency or office" *versus* "interventions in the context of the daily life of the client.")

Furthermore, the presentation of practice situations in such future research might be done in a more comprehensive format, by attempting to counterbalance not only for sequence of situational-vignette presentation, but also by attempting to account for idiosyncratic effects of particular vignettes on particular clinicians by having more than one vignette story which presents the same problem/situation. (The particulars about which clinician is presented with which vignette, and how many vignettes to present to each clinician, would clearly have to be worked out as part of the design of an experiment.)

Other dimensions of problem/situation could be utilized in the development of vignettes. It might be fruitful to pick dimensions which, again, might tend to pull clinical judgments toward one or the other school of practice, as a way of testing our hypotheses

under "extreme conditions," so to speak. Thus, in addition to the dimensions already employed, those such as "degree of client psychopathology" (a linear-oriented concept) and explicit "phase of life transitions" (an ecologically-oriented concept) might be conveyed in vignettes. Furthermore, the dimension of duration-severity could be broken down into a dimension of "duration" alone, and a dimension of "severity." The researcher could subdivide the dimension of "severity" into one which might reflect severity of psychopathology (linear), and one which might reflect severity of stress in entire system (ecological).

Such research could be follow-through and outcome-oriented research. Most interesting would be not only a comparison of outcome measures under varied client problem/situations (especially the chronic-isolated condition), under varied conditions of practice (as just outlined), *and* especially with open-ended, true-to-life reportage of assessments and intervention plans. Although the current study is *not* an effectiveness study, it does point to the utility of such empirically based research in relation to our two practice approaches.

A full appreciation of such outcome research would, necessarily, involve a critique of our Instrument-1, which served as the basis of our determination of each individual clinician's clinical-orientation. In any successor to Instrument-1 (to the extent that it is empirically possible) we might develop for all scales, a margin of several items above a minimum of ten, so that

we might increase the likelihood, after item elimination procedures, of ending up with at least ten items per scale in a final, internally reliable format. This was done for some scales, and not for other scales. A difficulty in doing this for all scales would appear to be the possibility that there may be a limitation in the extent to which a concept lends itself to being broken down into partialized, specific aspects which may be presented as statements to subjects.

Alternative approaches to dealing with this limitation would seem to lie in both form and substance. Formwise, the problem might be handled by the initial development of many items with similar partializations, but with carefully arranged alternative wording, to see if one or another form of wording format presents a higher reliability coefficient. This might promote the inclusion of items whose wording presents high reliability coefficients. Substantewise, a more expensive but useful alternative would be the use of a *panel* of experts to jointly develop item-content as well as the principles themselves from which the item-content is developed. The idea would be to tap the various aspects of theory which go into making up a clinician's orientation, in as fruitful a way as possible. Such a panel could also work out several different wording possibilities for each partialized concept which is represented in an item, toward the end of maximizing reliability scores for the overall instrument. This formalized use of *consensus* among *experts* could be especially useful, because

early decisions about content, its scope and its presentation, affect our later choices *and* enhance the content validity of our final results. Given the importance of the current dialectic, and the utility of agreed-upon definitions for any valid testing of practice alternatives, consensual validation of content by *experts* would enhance respectability of results.

Last, in order to keep the final format of such an instrument down to a number of items which will not overwhelm subjects, any increase in the number of final items per scale to a minimum of ten should go hand-in-hand with a lowering of the final number of scales to no more than four or five. This would allow for a maximum of about fifty items for subjects to deal with, and would thereby help to minimize effects of fatigue. Then, each scale, perhaps of ten to twelve items each, would present the interesting *potential* of being statistically testable as a separate instrument. There would also be fewer scales to analyze in our results. The idea would be to simplify the appearance of our results, and to simplify the process of data analysis, including the number of correlations which are necessary. This, in turn, would diminish, and hopefully simplify, the possible numbers of patterns to be distinguished among our data. Finally, a simpler instrument, whose content validity is recognized through expert consensus, might prove of value in ordinary clinical work, as well as in research.

Conclusion.

On the overall, we may conclude about this study, that meaningful differences exist between clinical-orientation groups in measures of judgments about assessments and intervention plans. These differences emerge or remain latent as a function of the controlled presence or absence of various forms of the situational factors which we have called duration-severity and interpersonal-context; and the method of data collection which consisted of either forced-choice or open-ended responses.

Notes

1. The notion of testing "alternate recommendations" is this author's adaptation of Merton's concept of testing "opposed recommendations" for the advancement of knowledge. Refer to Merton, R. K. (1959). Notes on Problem-Finding in Sociology: Introduction. In R. K. Merton (Ed.), Sociology Today (pp. ix-xxxiv). New York: Basic Books.

2. It is noteworthy that Hollis (1964, p. 208-9) sees these individual and social norms as indispensable in evaluations of clients' functioning. Norms are then indispensable for setting treatment goals toward more adaptive normative functioning.

3. While *one* motif about the place of COS in social work is emphasized here, COS was *not* monolithic. For example, COS in America "worked to effect the coordination of existing welfare services and agencies" (Reid, 1981, p. 49), and "to improve the health and social resources of the community." These functions eventually split into (a) family service, and (b) coordinating and planning councils (p. 53).

4. We note this, for example, in the elaborate procedures described by Richmond for the systematic gathering of specific, relevant data about clients in general, and about clients who belong to particular socially identifiable groups. These included immigrants and widows, clients with disabilities such as insanity, blindness, and feeble-mindedness (Richmond, 1917, pp. 373-448).

5. It is by its earlier title, "The Problem of Anxiety," that this paper is referred to by Rapaport (1959a).

6. Heinz Hartmann's Ego Psychology and the Problem of Adaptation, published in English translation in 1958, was originally published in German in 1939 as *Ich-Psychologie und Anpassungsproblem*, in Internationale Zeitschrift für Psychoanalyse und Imago.

7. For subsequent fuller development of the differentiation of id and ego from a common matrix, see Hartmann, H., Kris, E. & Loewenstein, R. M. (1946). Comments on the Formation of Psychic Structure. The Psychoanalytic Study of the Child. 2, 11-38. New York: International Universities Press.

8. In Chapter 5, "Methods of Access: Space," Kantor and Lehr discuss mechanisms used by a family to access and utilize its immediate space and that of the wider world in its life.

9. Altman discusses issues of privacy, personal space, territorial behavior, crowding and density.

10. Germain refers to:

(a) Park, R. E., Burgess, E. W. & McKenzie, R. (1925). The City. Chicago: University of Chicago Press.

(b) Hawley, A. (1950). Human Ecology: A Theory of Community Structure. New York: The Ronald Press. (Cited in text of this dissertation)

(c) Park, R. E. (1952). Human Communities: The City and Human Ecology. Glencoe, IL: The Free Press.

References

- Ainsworth, M. D. & Bell, S. M. (1974). Mother-infant interaction and the development of competence. In K.S. Connolly & J. Bruner (Eds.), The growth of competence (pp. 97-118). New York: Academic Press.
- Alexander, C. (1970). The goodness of fit and its source. In H. M. Proshansky, W. H. Ittelson & L. G. Rivlin (Eds.), Environmental Psychology: Man and His Physical Setting (pp. 42-56). New York: Holt, Rinehart & Winston, Inc.
- Allport, G. W. (1961). Pattern and growth in personality. New York: Holt Rinehart and Winston, Inc.
- Altman, I. (1975). The environment and social behavior. Monterrey CA: Brooks/Cole.
- Aponte, H. J. (1979). Diagnosis in family therapy. In C. B. Germain (Ed.), Social work practice: people and environments (pp. 107-149). New York: Columbia University Press.
- Auerswald, E. H. (1969). Interdisciplinary versus ecological approach. In W. Gray, F. J. Duhl & N.D. Rizzo (Eds.), General systems theory and psychiatry (pp. 373-386). Boston: Little, Brown.
- . (1971). Families, change and the ecological perspective. Family Process, 10, 263-280.
- Bartlett, H. M. (1970). The common base of social work practice. New York: National Association of Social Workers.
- Bandler, B. (1968). The concept of ego-supportive psychotherapy. In H. J. Parad & R. R. Miller (Eds.), Ego-oriented casework (pp. 27-44). New York: Family Service Association of America.
- Beels, C., M.D. & Ferber, A. M.D. (1969). Family therapy: A view. Family Process, 8, 280-318.
- Bertalanffy, L. von (1968). General systems theory. New York: George Braziller.
- . (1969). General systems theory and psychiatry--An overview. In W. Gray, Frederick J. Duhl and Nicholas D. Rizzo (Eds.), General systems theory and psychiatry (pp. 33-46). Boston: Little, Brown.

- . (1975a). New patterns of biological and medical thought. In E. Taschdjian (Ed.), Perspectives on general systems theory: Scientific-philosophical studies, by Ludwig von Bertalanffy (pp. 40-52). New York: George Braziller.
- . (1975b). Vahinger's Als-Ob: The role of fiction in science. In E. Taschdjian (Ed.), Perspectives on general systems theory: Scientific-philosophical studies, by Ludwig von Bertalanffy (pp. 67-73). New York: George Braziller.
- Bikales, G. (1975). The dog as 'significant other.' Social Work, 20, 150-152.
- Bloom, B. L. (1977). Community mental health. Monterey, CA: Brooks/Cole.
- Bowen, M. (1975). Family Therapy after Twenty Years. In Silvanbo Arieti (Ed.), The American handbook of psychiatry: Vol. 5 (2nd ed., pp. 367-392). New York: Basic Books.
- Bowlby, J. (1973). Affectional bonds: Their nature and origin. In Robert S. Weiss (Ed.), Loneliness: The experience of emotional and social isolation (pp. 30-52). Cambridge, MA: MIT Press.
- Bronfenbrenner, U. (1979). The ecology of human development: Experiments by nature and design. Cambridge, MA: Harvard University Press.
- Cartwright, D. (1959). Lewinian theory as a contemporary systematic framework. In Sigmund Koch (Ed.), Psychology: A study of a science. Study I: Conceptual systematic. Vol. 2: General systematic formulations and special processes (pp. 7-91). New York: McGraw-Hill.
- Cataldo, C. (1979). Wilderness therapy: Modern day shamanism. In Caryl B. Germain (Ed.), Social work practice: People and environments (pp. 47-73). New York: Columbia University Press.
- Chapman, A.H., M.D. (1976). Harry Stack Sullivan: His life and work. New York: G.P. Putnam.
- Chess, S., M.D., Fernandez, P., M.D. & Korn, S., Ph.D. (1980). The handicapped child and his family: Consonance and dissonance. Journal of American Academy of Child Psychiatry 19, 56-67.

- Chin, R. (1969). The utility of systems models and developmental models for practitioners. In W. G. Bennis, K. D. Benne and R. Chin (Eds.), The planning of change (pp. 308-311). New York: Holt, Rinehart & Winston.
- Cohen, N. (1947). Body of knowledge and skills basic to group work. In American Association of Group Work (Comp.), Toward professional standards. New York: Association Press.
- Cooper, C. (1976). The house as symbol of the self. In H. M. Proshansky, W. H. Ittelson and L. J. Rivlin (Eds.), Environmental psychology (2nd, ed., pp. 435-448). New York: Holt, Rinehart & Winston.
- Cottrell, L. (1976). The competent community. In B. H. Kaplan, R. N. Wilson, & A. H. Leighton. (Eds.), Further explorations in social psychiatry (pp. 195-209). New York: Basic Books.
- Coulton, C. J. (1979). Developing an instrument to measure person-environment fit. Journal of Social Service Research, 3, 2, 159-173.
- . (1981). Person-environment fit as a focus of health care. Social Work, 26, 26-35.
- Council on Social Work Education. (1971). Manual of accrediting standards for graduate professional schools of social work. New York: Author.
- Coyle, G. (1939). Social process in organized groups. New York: Richard R. Smith.
- . (1946). Group work in recreation. Proceedings of the National Conference of Social Work (pp. 202-208). New York: Columbia University Press.
- . (1947). Group work: A method in recreation. The Group (April, 1947), 9, 8-11.
- DeLone, R. (1979). Small futures: Children, inequality, and the limits of liberal reform. New York: Harcourt, Brace, Jovanovich.
- deSchweinitz, K. (1943). England's road to social security. Philadelphia: University of Pennsylvania Press.
- Dinerman, M., DSW. (1981). Social work curriculum at the baccalaureate and masters levels. New York: The Lois and Samuel Silberman Fund.

- Draper, B. J. (1979) Black language as an adaptive response to a hostile environment. In C. B. Germain (Ed.), Social work practice: People and environments (pp. 267-281). New York: Columbia University Press.
- Dubos, R. (1965). Man adapting. New Haven: Yale University Press.
- . (1968). So human an animal. New York: Scribner's.
- . (1972). A god within. New York: Charles Scribner's Sons.
- Egler, F. E. (1968). Pesticides--in our ecosystem. In P. Shepard & D. McKinley (Eds.), The subversive science: Essays toward an ecology of man. Boston: Houghton-Mifflin.
- Erikson, E. H. (1959a). Growth and crisis of the healthy personality. In E. Erikson, Identity and the life cycle: Selected papers by Erik Erikson, with a historical introduction by David Rapaport. Psychological Issues, 1, (1, Monograph 1, pp. 50-100). New York: International Universities Press.
- . (1959b). The problem of ego identity. In E. Erikson, Identity and the Life Cycle: Selected papers by Erik Erikson, with a historical introduction by David Rapaport. Psychological Issues, 1, (1, Monograph 1, pp. 101-164). New York: International Universities Press.
- . (1950). Childhood and society. New York: W.W. Norton.
- Foote, N. N. & Cottrell, L. S., Jr. (1955). Identity and interpersonal competence. Chicago: University of Chicago Press.
- Freud, A. (1966). The Ego and the Mechanisms of Defense (rev. ed.). New York: International Universities Press. (Original work published in 1936)
- Freud, S. (1953). The interpretation of dreams. In James Strachey (Ed. and Trans.), The standard edition of the complete works of Sigmund Freud (Vols. 4 & 5). London: Hogarth Press. (Original work published in 1900)
- . (1953). Three essays on the theory of sexuality. In James Strachey (Ed. and Trans.), The standard edition of the complete works of Sigmund Freud (Vol. 7, pp. 123-245). London: Hogarth Press. (Original work published in 1905)

- . (1961). The ego and the id. In James Strachey (Ed. and Trans.), The standard edition of the complete works of Sigmund Freud (Vol. 19, pp. 1-66). London: Hogarth Press. (Original work published in 1923)
- . (1959). Inhibitions, symptoms and anxiety. In James Strachey (Ed. and Trans.), The standard edition of the complete works of Sigmund Freud (Vol. 20, pp. 1-59). London: Hogarth Press. (Original work published as The Problem of Anxiety in 1926)
- . (1964). New introductory lectures. Lecture 31: The anatomy of the mental personality. In James Strachey (Ed. and Trans.), The standard edition of the complete works of Sigmund Freud (Vol. 22, pp. 57-80). London: Hogarth Press. (Original work published in 1932)
- . (1964). Analysis terminable and interminable. In James Strachey (Ed. and Trans.), The standard edition of the complete works of Sigmund Freud (Vol. 23, pp. 209-254). London: Hogarth Press. (Original work published in 1937)
- & Breuer, J. (1955). Studies on hysteria. In James Strachey (Ed. and Trans.), The standard edition of the complete works of Sigmund Freud (Vol. 2, pp. 1-305). London: Hogarth Press. (Original work published in 1895)
- Garvin, C., & Glasser, P. (1971). Social group work: The preventive and rehabilitative approach. Encyclopedia of Social Work (Vol 1., pp. 1263-1272). New York: National Association of Social Workers.
- Germain, C. B. (1970). Casework and Science: A Historical Encounter. In R. W. Roberts & R. H. Nee (Eds.), Theories of Social Casework (pp. 3-32). Chicago. University of Chicago Press.
- . (1971). Casework and science: A study in the sociology of knowledge. Unpublished doctoral dissertation, Columbia University School of Social Work.
- . (1973a). An ecological perspective in casework practice. Social Casework 54, 323-330.
- . (1973b) Social Casework. In H. B. Trecker (Ed.), Goals for social welfare 1973-1993: An overview of the next two decades (pp. 125-137). New York: Association Press.

- . (1978a). General systems theory and ego psychology: An ecological perspective. Social Service Review, 52, 535-550.
 - . (1978b). Space: An ecological variable in social work practice. Social Casework, 59, 515-522.
 - . (1981). An ecological approach to people-environment transactions. Social Casework, 62, 323-331.
 - . (1983). Using social and physical environments. In A. Rosenblatt and D. Waldfogel (Eds.), Handbook of clinical social work (pp. 110-133). San Francisco: Jossey-Bass.
 - . (1985). The place of community work within an ecological approach to social work practice. In S. H. Taylor & R. W. Roberts (Eds.), Theory and practice of community social work (pp. 30-55). New York: Columbia University Press.
 - . (1987) Human development in contemporary environments. Social Service Review, 61, 565-580.
 - & Gitterman, A. (1975). Social work practice: An integrated approach. Unpublished manuscript. Columbia University School of Social Work. (Made available by the authors)
 - & --- . (1980). The life model of social work practice. New York: Columbia University Press.
 - & --- . (1983). Life model of practice. Letter in comments from readers. Social Casework, 64, 61-62.
 - & --- . (1987). Ecological perspective. Encyclopedia of Social Work (Vol. 1, pp. 488-499). Silver Spring, MD: National Association of Social Workers.
- Gitterman, A. (1985/86). The reciprocal model: A change in the paradigm. In The legacy of William Schwartz: Group process as shared interaction. Social Work with Groups, 8, 29-37.
- & Germain, C. B.. (1976a). An integrated perspective on social work practice. Unpublished manuscript. (Made available by the authors)
 - & --- . (1976b). Social work practice: A life model. Social Service Review, 50, 601-610.
- Gladwin, T. (1973). Social competence and clinical practice. Psychiatry, 30, 30-43.

- Glaser, J. S. (1972). The stairwell society of public housing. Comparative Group Studies, 3, 159-173.
- Glenn, J., M.D. (1980). Notes on psychoanalytic concepts and style in Freud's case histories. In M. Kanzer, M.D., & J. Glenn, M.D. (Eds.), Freud and his patients. New York: Jason Aronson.
- Glossup, R. (1988). Bronfenbrenner's ecology of human development: A reappraisal. In A. R. Pence (Ed.), Ecological research with children and families (pp. 1-15). New York: Teachers College Press.
- Goldstein, E. S. (1984) Ego psychology and social work practice. New York: The Free Press, A Division of Macmillan.
- . (1986). Ego psychology. In F. J. Turner. (Ed.), Social work treatment: Interlocking theoretical approaches (3rd ed., pp. 375-405). New York: The Free Press, A Division of Macmillan.
- Gordon, William E. (1969). Basic constructs for an integrative and generative conception of social work. In G. A. Hearn (Ed.), The general systems approach: Contributions toward an holistic conception of social work (pp. 5-11). New York: Council on Social Work Education.
- . (1983). Social work revolution or evolution. Social Work, 28, 181-185.
- Gray, W. & Rizzo, N. D. (1969). History and development of general systems theory. In W. Gray, F. J. Duhl and N. D. Rizzo (Eds.), General systems theory and psychiatry (pp. 7-31). Boston: Little, Brown.
- Greiff, G. L. (1986). The ecosystems perspective meets the press. Social Work, 31, 225-226.
- Group for the Advancement of Psychiatry (1970). The field of family therapy. GAP Report No. 78, 7, 531-624.
- Guerin, P. J., Jr., M.D. (1976). Family therapy: The first twenty-five years. In P. J. Geurin, Jr., M.D. (Ed.), Family therapy, theory and practice (pp. 2-22). New York: Halstead Press, Division of John Wiley and Sons.
- Guntrip, H. Ph.D. (1973). Psychoanalytic theory, therapy, and the self. New York: Basic Books.

- Haley, J. (1971a). A review of the family therapy field. In J. Haley (Ed.), A family therapy reader (pp. 1-12). New York: Grune & Straton.
- . (1971b). Approaches to family therapy. In J. Haley (Ed.), Changing families (227-236). New York: Grune & Straton.
- Hall, C. S. & Lindsey, G. (1970). Chapter six: Lewin's field theory. In C. S. Hall & G. Lindsey, Theories of personality (2nd ed., pp. 209-257). New York: John Wiley and Sons.
- Hamilton, G. (1940). Theory and practice of social casework. New York: Columbia University Press.
- . (1951). Theory and practice of social casework (2nd ed.). New York: Columbia University Press.
- Hareven, T. K. (1982). The life course and aging in historical perspective. In T. K. Hareven and K. J. Adams (Eds.), Aging and life course transitions: An interdisciplinary perspective (pp. 1-26). New York: Guilford Press.
- Hartford, M. E. (1971). Groups in social work. New York: Columbia University Press.
- . (1976). Group methods and generic practice. In R. W. Roberts & H. Northen (Eds.), Theories of social work with groups (45-74). New York: Columbia University Press..
- Hartman, (L.) A. (1979). The extended family as a resource for change: An ecological approach to family-centered practice. In C. B. Germain (Ed.), Social work practice: People and environments--An ecological perspective (pp. 240-266). New York: Columbia University Press.
- & Laird, J. (1983). Family-centered social work practice. New York: The Free Press, A Division of Macmillan.
- Hartmann, H. (1952). The mutual influences in the development of the ego and the id. The Psychoanalytic Study of the Child, 7, 9-30. New York: International Universities Press.
- . (1958). Ego psychology and the problem of adaptation (D. Rapaport, Trans.). International Universities Press. (Original work published in 1939)
- , Kris, E. & Loewenstein, R. M. (1946). Comments on the foundation of psychic structure. The Psychoanalytic Study of the Child, 2 (pp. 11-38). New York: International Universities Press.

- Hawley, A. (1950). Human ecology: A theory of community structure. New York: The Ronald Press.
- Hellenbrand, S. (1965). Main currents in social casework, 1918-1936. Unpublished doctoral dissertation. Columbia University School of Social Work.
- Hendrick, I. (1942). Instinct and the ego during infancy. Psychoanalytic Quarterly, 11, 33-58.
- . (1943). Work and the pleasure principle. Psychoanalytic Quarterly, 12, 311-329.
- Henry, J. (1973). Pathways to madness. New York: Vintage.
- Hollis, F. (1964). Casework: A psychosocial therapy. New York: Random House.
- Jackson, D. D. (1969). The individual and the larger contexts. In W. Gray, M.D., F. J. Duhl, M.D., and N. J. Rizzo, M.D. (Ed.s), General systems theory and psychiatry (pp. 387-396). Boston: Little, Brown.
- Janchill, Sister M. P. (1969). Systems concepts in casework theory and practice. Social Casework, 50, 74-82.
- Jones, E. (1957). The life and work of Sigmund Freud (Vol. 3). New York: Basic Books.
- Kantor, D. & Lehr, W. (1975). Inside the family. San Francisco: Josey-Bass.
- Kardiner, A., M.D., with Spiegel, H., M.D. (Collab.). (1947). Wartime stress and neurotic illness. New York: Paul B. Hoher.
- Katz, A. J. (1965). Applications of self-help concepts in current social welfare. Social Work, 10, 68-74.
- & Bender, E. I. (1976). The strength in us: Self-help in the modern world. New York: Franklin Watts Press.
- Klein, A. (1953). Society, democracy and the group. New York: Woman's Press.
- Konopka, G. (1949). Therapeutic group work with children. Minneapolis: University of Minnesota Press.
- . (1954). Group work in the institution: A modern challenge. New York: Association Press.

- Kuhn, T. S. (1970). The structure of scientific revolutions (2nd ed., enlarged). Chicago: University of Chicago Press.
- Lee, J. A. B. & Swenson, C. R. (1986). The concept of mutual aid. In A. Gitterman & L. Shulman (Eds.), Mutual aid and the life cycle (pp. 361-377). Itasca IL: F.E. Peacock.
- Levy, L. H. (1973). Self-help groups as mental health resources. Bloomington IN: Indiana University Press.
- Lewin, K. (1951). Field theory and experiment in social psychology. In D. Cartwright, (Ed.), Field theory in social science: Selected theoretical papers (pp. 130-154). New York: Harper Brothers. (Original work published in 1939)
- . (1951). Defining the field at a given time. In D. Cartwright (Ed.), Field theory in social science: Selected theoretical papers. (pp. 43-59). New York: Harper Brothers. (Original work published in 1943)
- . (1951). Behavior and development as a function of the total situation. In D. Cartwright (Ed.), Field theory in social science: Selected theoretical papers (pp. 43-59). New York: Harper Brothers. (Original work published in 1946)
- Lincoln, Y. S. & Guba, E. G. (1985). Naturalistic inquiry. Beverly Hills: Sage.
- Lippitt, R., Watson, J. & Westley, B. (1958). The dynamics of planned change: A comparative study of principles and techniques. New York: Harcourt, Brace & World.
- Lubove, R. (1965). The professional altruist: The emergence of social casework as a career, 1880-1930. Cambridge: Harvard University Press.
- Lutz, W. A. (1968). Emerging models of social casework practice. Unpublished paper. University of Connecticut, School of Social Work. (Made available at Columbia University School of Social Work in 1972)
- Lutz, W. A. (1956). Concepts and principles underlying social casework practice. Social Work Practice in Medical Care and Rehabilitation Settings (Monograph No. 3). Washington, D.C: National Association of Social Workers, Medical Social Work Section.

- Maluccio, A. N. (1974). Action as a tool in casework practice. Social Casework, 55, 30-35.
- . (1979a). Learning from clients: Interpersonal helping as viewed by clients and social workers. New York: Free Press.
- . (1979b). Promoting competence through life experiences. In C. B. Germain (Ed.), Social work practice: people and environments (pp. 282-302). New York: Columbia University Press.
- . (1981). Competence-oriented social work practice: An ecological approach. In A. N. Maluccio (Ed.), Promoting competence in clients: A new/old approach to social work practice (pp. 1-24). New York: The Free Press, Division of MacMillan.
- & Marlow, W. D. (1974). The case for the contract. Social Work, 19, 28-36.
- McCall, R. B. (1977). Challenges to the science of developmental psychology. Child Development, 48, 333-344.
- McHarg, I. L. (1969). An ecological method for landscape architecture. In P. Shepard & D. Mckinley (Eds.), The subversive science: Essays toward an ecology of man (pp. 328-332). Boston: Houghton Mifflin.
- Mead, M. (1970). Culture and commitment: A study of the generation gap. New York: Natural History Press.
- Mechanic, D. (1974). Social structure and personal adaptation: Some neglected dimensions. In G. V. Coelho, D. A. Hamburg & J. E. Adams (Eds.), Coping and adaptation (pp. 32-46). New York: Basic Books.
- Meyer, C. H. (1983a). The search for coherence. In C. H. Meyer (Ed.), Clinical social work in the eco-systems perspective (pp. 5-34). New York: Columbia University Press.
- . (1983b). Beginning again. In C. H. Meyer (Ed.), Clinical social work in the eco-systems perspective (pp. 238-254). New York: Columbia University Press.
- . (1987). Direct practice in social work: Overview. Encyclopedia of Social Work (Vol. I, pp. 409-422). Washington, D.C.: National Association of Social Workers.
- Middleman, R. & Goldberg, G. (1974). Social service delivery: A structural approach to social work practice. New York: Columbia University Press.

- Miller, J. G. (1969). Living systems: Basic concepts. In W. Gray, F. J. Duhl & N. D. Rizzo (Eds.), General systems theory and psychiatry (pp. 51-133). Boston: Little, Brown.
- Mills, C. W. (1959). The sociological imagination. New York: Oxford University Press.
- Mishne, J. M. (1982). The missing system in social work's application of systems theory. Social Casework, 63, 547-553.
- Mittleman, B. (1954). Motility in infants, children, and adults: Patterning psychodynamics. Psychoanalytic Study of the Child, 9, (pp. 142-177). New York: International Universities Press.
- Munroe, R. L. (1955). Schools of psychoanalytic thought. New York: Holt, Rinehart & Winston.
- Murray, H. A. & Kluckhohn, C. (1953). Outline of a conception of personality. In C. Kluckhohn, H. A. Murray, & D. M. Schneider (Eds.), Personality in nature, society and culture (2nd ed., pp. 3-49). New York: Knopf.
- Northen, H. & Roberts, R. W. (1976). The status of theory. In R. W. Roberts & H. Northen (Eds.), Theories of social work with groups (pp. 368-344). New York: Columbia University Press.
- Nunberg, H. (1931). The synthetic function of the ego. International Journal of Psychoanalysis, 12, 123-140.
- Olson, D. (1970). Marital and family therapy: An integrated review and critique. Journal of Marriage and the Family, 32, 501-538.
- Orcutt, B. A. (1962). Anchoring Effects in the Clinical Judgments of Social Work Students and Experienced Caseworkers. Unpublished Doctoral Dissertation, Columbia University School of Social Work.
- Oxley, G. (1971). A life model approach to change. Social Casework, 52, 627-633.
- Parsons, T. (1964). Social structure and the development of personality: Freud's contribution to the integration of psychology and sociology. In N. J. Smelser & W. T. Smelser (Eds.), Personality and social systems (pp. 33-54). New York: John Wiley and Sons.

- Peterfreund, E. (1971). Information, systems and psychoanalysis. Psychological Issues (Monographs Nos. 25 & 26). New York: International Universities Press.
- Phillips, H. U. (1957). Essentials of social group work skill. New York: Association Press.
- Pincus, A. & Minahan, R. (1973). Social work practice: model and method. Itasca, Ill: F.E. Peacock Press.
- Piven, F. F. & Cloward, R. A. (1971). Regulating the poor: The foundations of public welfare. New York: Vintage Books, A Division of Random House.
- Rapaport, D. (1959a). Introduction: A historical survey of psychoanalytic ego psychology. In Identity and the life cycle: Selected papers by Erik Erikson, with a historical introduction by David Rapaport. Psychological Issues, 1, (1, Monograph 1, pp. 5-17). New York: International Universities Press.
- . (1959b). The Structure of psychoanalytic theory: A systematizing attempt. In Sigmund Koch (Ed.), Psychology: A study of science. Study I: Conceptual and systematic. Volume 3: Formulations of the person and the social context (pp. 55-183). New York: McGraw Hill.
- Redl, F. (1959). Strategies and techniques of the life space interview. American Journal of Orthopsychiatry, 29, 1-18.
- Reid, K. E. (1981). From character building to social treatment: The history of the use of groups in social work. Westport, CT: Greenwood Press.
- Richmond, M. (1917). Social diagnosis. New York: Russell Sage.
- . (1922). What is social casework? New York: Russell Sage.
- Riley, M. W. (1978). Aging, social change, and the power of ideas," Daedalus, No. 107, 39-52.
- . (1985). Women, men, and the lengthening life course. In A. K. Rossi (Ed.), Gender and the life course (333-347). New York: Aldine Publishing.
- Roazen, P. (1976). Erik H. Erikson: The power and limits of a vision. New York: The Free Press, A Division of Macmillan.

- Rodwell, M. K. (1987). Naturalistic inquiry: An alternative model for social work assessment. Social Service Review, 61, 231-246.
- Rogers, E. S. (1960). Human ecology and health: An introduction for administrators. New York: Macmillan.
- Rothman, B. & Papell, C. (1966). Social group work models: Possession and heritage. Education for Social Work, 2, 66-77.
- Schwartz, W. (1959). Group work and the social scene. In A. J. Kahn (Ed.), Issues in American social work (pp. 110-137). New York: Columbia University Press.
- . (1961). The Social worker in the group. In Social Welfare Forum (pp. 146-177). New York: Columbia University Press.
- . (1964). Analysis of papers presented on working definitions of group work practice. In Margaret Hartford (Ed.), Working papers toward a frame of reference for social group work--1959-1963, (pp. 53-61). New York: National Association of Social Workers.
- . (1969). Private troubles and public issues: One social work job or two? Social Welfare Forum, 1969 (pp. 22-43). New York: Columbia University Press.
- . (1971). Social group work: The interactionist approach. Encyclopedia of Social Work (pp. 1252-1263). New York: National Association of Social Workers.
- . (1976). Between client and system: The mediating function. In R. W. Roberts & H. Northen. Theories of social work with groups (pp. 171-197). New York: Columbia University Press.
- Searles, H. (1960). The non-human environment. New York: International Universities Press.
- Shearer, R. M. (1978). Overnight trips for chronic psychiatric patients. Social Work, 23, 324-325.
- Shepard, P. (1969). Introduction: Ecology and man--A viewpoint. In P. Shepard & D. McKinley (Eds.), The subversive science, essays toward an ecology of man (pp. 1-10). Boston: Houghton-Mifflin.
- Sherz, F. H. (1953). What is family-centered casework? Social Casework 34, 343-349.

- . (1962). Multiple-client interviewing: Treatment implications. Social Casework, 43, 120-125.
- . (1963). Family interaction: Some problems and implications for casework. In H. J. Parad & R. R. Miller (Eds.), Ego-oriented casework: Problems and perspectives (pp. 129-44). New York: Family Service Association of America. (Paper originally presented at meeting of the Smith College School for Social Work Alumnae Association, Chicago, November 16, 1959)
- . (1970). Theory and practice of family therapy. In R. W. Roberts & R. H. Nee. Theories of social casework (pp. 219-264). Chicago: University of Chicago Press.
- Shulman, L. & Gitterman, A. (1986). The life model, mutual aid and the mediating function. In A. Gitterman & L. Shulman (Eds.), Mutual aid groups and the life cycle (3-22). Itasca, IL: F.E. Peacock Publishers.
- Spiegel, J. P. (1958). Some cultural aspects of transference and countertransference. In J. H. Masserman (Eds.), Science and psychoanalysis: Volume II. Individual and family dynamics, (pp. 160-182). New York: Grune & Stratton.
- . (1971). Transactions: The interplay between individual, family and society. New York: Science House.
- Sroufe, L. A. & Waters, E. (1977). Attachment as an organizational construct. Child Development, 48, 1184-1199.
- Stein, I. (1974). Systems theory, science and social work. Metuchen, NJ: Scarecrow Press.
- Stern, D. (1977). The first relationship. Cambridge, MA: Harvard University Press.
- . (1985). The interpersonal world of the human infant. New York: Basic Books.
- Stokols, D. (1977). Origins and directions of environment-behavioral research. In D. Stokols (Ed.), Perspectives on environment and behavior: Theory, research, and applications (pp. 5-36). New York: Plenum Press.
- Sullivan, H. S. (1953). The interpersonal theory of psychiatry. New York: W.W. Norton.

- Sundberg, N. D., Snowden L. R. & Reynolds, W. M. (1978). Toward assessment of personal competence and incompetence in life situations. Annual Review of Psychology, 29, 179-221.
- Swenson, C. (1979). Social networks, mutual aid, and the life model of practice. In C. B. Germain (Ed.), Social work practice: People and environments--An ecological perspective (213-235). New York: Columbia University Press.
- Thomas, A. (1981). Current trends in developmental theory. American Journal of Orthopsychiatry, 51, 580-609.
- & Chess, S. (1977). Temperament and development. New York: Bruner/Mazel.
- & --- . (1980). The dynamics of psychological development. New York: Bruner/Mazel.
- Thomas, E. J. (1980). Beyond knowledge utilization in generating human service technology. In D. Fanshel (Ed.), The future of social work research (pp. 91-103). Washington, D.C.: National Association of Social Workers.
- Toffler, A. (1971). Future shock. New York: Bantam Books.
- Tropp, E. (1971). Social group work: The developmental approach. Encyclopedia of Social Work (1246-1152). New York: National Association of Social Workers.
- Vassil, T. (1978). Residential family camping: Altering family patterns. Social Casework, 59, 605-613.
- Waelder, R. (1936). The principle of multiple function: observations on overdetermination. Psychoanalytic Quarterly, 5, 42-62.
- Walsh, F. (1983). Family therapy: A systemic orientation to treatment. In A. Rosenblatt & D. Waldfogel (Eds.), Handbook of clinical social work (pp. 466-489). San Francisco: Jossey-Bass.
- Weick, A. (1981). Reframing the person-in-environment perspective. Social Work, 26, 140-143.
- Weiss, R. S. (1973). The nature of loneliness. In R. S. Weiss (Ed.), Loneliness: The experience of emotional and social isolation (pp. 9-29). Cambridge, MA: MIT Press.

- . (1982). Attachment in adult life. In C. M. Parkes & J. Stevenson-Hinde (Ed.), The place of attachment in human behavior (pp. 171-184). New York: Basic Books.
- White, R. W. (1959). Motivation reconsidered: The concept of competence. Psychological Review, 66, 297-333.
- . (1960). Competence and psychosexual stages of development. In M. Jones (Ed.), Nebraska symposium on motivation (pp. 97-144). Lincoln, Nebraska: University of Nebraska Press.
- . (1963). Ego and reality in psychological theory: A proposal regarding independent ego energies. Psychological Issues, 3, (3, Monograph 11). New York: International Universities Press.
- Willems, E. P. (1977). Behavioral ecology. In D. Stokols (Ed.), Perspectives on environment and behavior: Theory research, and applications (pp.37-68). New York: Plenum Press.
- Wilson, E. O. (1978). On human nature. Cambridge, MA: Harvard University Press.
- Wilson, G. (1976). From practice to theory: A personalized history. In R. W. Roberts & H. Northen (Eds.), Theories of social Work with groups (pp. 2-44). New York: Columbia University Press.
- & Ryland, G. (1949). Social group work practice. New York: Houghton Mifflin.
- Winer, B. J. (1971). Statistical principles in experimental design (2nd ed.). New York: McGraw-Hill.
- Wohlwill, J. F. (1983). The concept of nature: A psychologist's view. In I. Altman & J. F. Wohlwill (Eds.), Behavior and the natural environment (pp. 5-37). New York: Plenum Press.
- Woodroffe, K. (1966). From charity to social work. London: Routledge and Kegan Paul.
- Young-Breuhl, E. (1988). Anna Freud: A biography. New York: Summit Books.

APPENDIX A

Introductory Questionnaire

CLINICAL JUDGMENTS PROJECT
EZRA TEITELBAUM, C.S.W.

NEW YORK, N.Y. 10025

(212)

Dear Second Year Social Work Student:

I am a doctoral candidate at Columbia University School of Social Work. The "Clinical Judgments Project" is my dissertation research. I am requesting all second year students in casework or direct practice at your school to consider participating. Participants will be paid.

If you participate, there will be two questionnaires in the near future to complete and return by mail. The first should take no more than a half hour. If you complete and return it, you will be paid \$5.00. The second questionnaire should take about an hour, and will be distributed several weeks after the first. About half the participants will be selected to complete and return the second questionnaire, and will be paid an additional sum of \$10.00 for their effort.

All individual responses will be treated confidentially and anonymously, without reference to anyone's name.

The purpose of this project is to understand how different social work clinicians think about a case. It is not intended to judge competence. No data about competence will be sought. I will be happy, at your individual request, to let you know the outcome of this study, after all data have been collected.

Thank you for your interest and participation which, you can be assured, I desperately need in order to complete my research and get my degree!

Sincerely yours,

Ezra Teitelbaum, C.S.W., ACSW

* * * * *

INSTRUCTIONS:

1. If you wish to participate please check this box. ☐
2. Write your name: _____
3. Your address: _____

4. Phone where you can
be reached: area code ____ / number ____ /
5. Fill out the brief questionnaire on the reverse side.
6. Return this form in the attached envelope.
7. You will be contacted in several weeks about participation.

* If you do not wish
* to participate,
* check here. ☐
*
* Then, please complete
* the questionnaire on
* the reverse side and
* return in the attached
* envelope. You will
* not be contacted any
* further.
*
* If you will not be a
* participant, I would
* appreciate your giving
* me your name below,
* but that is not
* required:
*
* _____
*
*
*

INTRODUCTORY QUESTIONNAIRE

Please answer the following questions briefly.

1. Which School of Social Work do you attend? _____
2. Are you a full-time matriculated student? Yes _____ No _____
3. What is your year of study? 1st year _____ 2nd year _____
4. What is your area of specialization? _____
5. What was your field placement last year? _____
 - (a) Function or type of agency: _____
 - (b) Nature or title of your assignment: _____
6. What is your current field placement? _____
 - (a) Function or type of agency: _____
 - (b) Nature or title of your assignment: _____
7. My primary professional interest at this time is work with: (check one or two)

individuals _____	agencies, _____
	organizations
families _____	communities _____
groups _____	other _____
	(specify)
8. As of now, my career goal is (specify briefly): _____
9. Sex: Male _____ Female _____
10. Age: How old are you? _____
11. Prior experience: How many years of social work or related experience have you had before attending social work school? _____
12. Do you have a graduate degree in a field other than social work? _____

If yes, please specify: Degree _____ Field _____

APPENDIX B

Instrument-1
with letter

CLINICAL JUDGMENTS PROJECT
EZRA TEITELBAUM, C.S.W.

NEW YORK, N.Y. 10025

(212)

Dear Graduating Second Year Social Work Student:

I am a doctoral candidate at Columbia University School of Social Work. The Clinical Judgments Project is my dissertation research.

When I wrote to you in February, you agreed to participate. I wish to thank you very much for your very needed participation.

As I had indicated in my introductory letter, there are two questionnaires as the basic instruments for this research. The first questionnaire is attached to this letter and should take no more than a half hour to complete. Please complete it and return it in the enclosed stamped return envelope. You will be sent a check for \$5.00 for your trouble.

Many of you will then be asked, in several weeks, to complete and return a second questionnaire of about an hour. For this, as indicated in my prior letter, you will be paid an additional \$10.00.

Again, all responses will be treated confidentially and anonymously without reference to anyone's name. The purpose of this project is to understand how different social work clinicians think about a case. It is not intended to judge competence. No data on competence will be sought. I will be happy, as I have indicated, at your individual request, to let you know the outcome of this study.

Please be so kind as to return the material at your earliest convenience. Your interest and participation are most valued and needed, in order for me to complete this research and earn my degree! Thank you.

Sincerely yours,

Ezra Teitelbaum, C.S.W., ACSW

INSTRUCTIONS: Please write your name and address to which a check may be sent, and to which, possibly a second questionnaire may be sent. Please return this with the completed questionnaire in the enclosed stamped return envelope. This information will be kept separately from your responses.

NAME _____

ADDRESS _____

Telephone where you can be reached: area code _____ number _____

Following are fifty brief multiple choice questions.

Please mark only one choice for each question.

Mark your answer with with an X in the proper space after each question.

Choose one of the following responses to each question:

- (1) Strongly agree
- (2) Agree
- (3) Neutral, neither agree nor disagree
- (4) Disagree
- (5) Strongly disagree
- (6) Not applicable

Please answer all questions.

Note: In the following questions, the word "client" is used in a generic sense and may be interpreted and defined by you according to your own usage in your own practice.

	(1) STRONGLY AGREE	(2) AGREE	(3) NEUTRAL	(4) DISAGREE	(5) STRONGLY DISAGREE	(6) DOES NOT APPLY
Part E: Instrument - 1 (Revised)						
(1) 1. When I evaluate a case, I assume there is <u>one</u> kind of growth and healthy change.	1. <u>(1)</u>	<u>(2)</u>	<u>(3)</u>	<u>(4)</u>	<u>(5)</u>	<u>(6)</u>
* (1) 2. When I evaluate a case, I assume there are <u>many</u> kinds of growth and healthy change.	2. <u>(1)</u>	<u>(2)</u>	<u>(3)</u>	<u>(4)</u>	<u>(5)</u>	<u>(6)</u>
(1) 3. When I evaluate a case, I assume that <u>one</u> possible intervention will lead to a particular type of effective change.	3. <u>(1)</u>	<u>(2)</u>	<u>(3)</u>	<u>(4)</u>	<u>(5)</u>	<u>(6)</u>
* (1) 4. When I evaluate a case, I assume that <u>many</u> possible intervention plans may lead to a particular type of effective change.	4. <u>(1)</u>	<u>(2)</u>	<u>(3)</u>	<u>(4)</u>	<u>(5)</u>	<u>(6)</u>
(1) 5. When I evaluate a case, I assume that a current problem is primarily the result of <u>one</u> main factor.	5. <u>(1)</u>	<u>(2)</u>	<u>(3)</u>	<u>(4)</u>	<u>(5)</u>	<u>(6)</u>
* (1) 6. When I evaluate a case, I assume that a current problem is primarily the result of <u>many</u> factors acting in concert.	6. <u>(1)</u>	<u>(2)</u>	<u>(3)</u>	<u>(4)</u>	<u>(5)</u>	<u>(6)</u>
(1) 7. When I evaluate a case, I assume that a current problem is the result of one possible sequence of factors, rather than several possible sequences.	7. <u>(1)</u>	<u>(2)</u>	<u>(3)</u>	<u>(4)</u>	<u>(5)</u>	<u>(6)</u>
(1) 8. Human behavior is determined by specific "laws" of science or nature.	8. <u>(1)</u>	<u>(2)</u>	<u>(3)</u>	<u>(4)</u>	<u>(5)</u>	<u>(6)</u>
(1) 9. Human behavior can be predicted if we know these "laws" and have sufficient information about the person(s) involved.	9. <u>(1)</u>	<u>(2)</u>	<u>(3)</u>	<u>(4)</u>	<u>(5)</u>	<u>(6)</u>
(1) 10. Human behavior can be changed if we know these "laws" and have sufficient information about the person(s) involved.	10. <u>(1)</u>	<u>(2)</u>	<u>(3)</u>	<u>(4)</u>	<u>(5)</u>	<u>(6)</u>
* (2) When I evaluate a case, I place the greatest emphasis on current factors.	11. <u>(1)</u>	<u>(2)</u>	<u>(3)</u>	<u>(4)</u>	<u>(5)</u>	<u>(6)</u>
* (2) When I evaluate a case, I place the greatest emphasis on future goals.	12. <u>(1)</u>	<u>(2)</u>	<u>(3)</u>	<u>(4)</u>	<u>(5)</u>	<u>(6)</u>
(2) When I evaluate a case, I place the greatest emphasis on etiology.	13. <u>(1)</u>	<u>(2)</u>	<u>(3)</u>	<u>(4)</u>	<u>(5)</u>	<u>(6)</u>
* (2) When I plan interventions in a case, I place the greatest emphasis on current factors.	14. <u>(1)</u>	<u>(2)</u>	<u>(3)</u>	<u>(4)</u>	<u>(5)</u>	<u>(6)</u>
* (2) When I plan interventions in a case, I place the greatest emphasis on future goals.	15. <u>(1)</u>	<u>(2)</u>	<u>(3)</u>	<u>(4)</u>	<u>(5)</u>	<u>(6)</u>

		(1) STRONGLY AGREE	(2) AGREE	(3) NEUTRAL	(4) DISAGREE	(5) STRONGLY DISAGREE	(6) DO NOT APPLY	
(2)	When I plan interventions in a case, I place the greatest emphasis on etiology.	16.	(1)	(2)	(3)	(4)	(5)	(6)
*(2)	I assume that some spontaneous change and growth cannot be explained on the basis of psychosocial factors.	17.	(1)	(2)	(3)	(4)	(5)	(6)
*(2)	Growth is a <u>purpose</u> to human behavior.	18.	(1)	(2)	(3)	(4)	(5)	(6)
*(2)	Reproducing and enhancing the next generation is a <u>purpose</u> to human behavior.	19.	(1)	(2)	(3)	(4)	(5)	(6)
(3)	20. I can best understand a case by separately viewing its many particular characteristics.	20.	(1)	(2)	(3)	(4)	(5)	(6)
*(3)	I can best understand a case by viewing the manner in which all its aspects interact with one another.	21.	(1)	(2)	(3)	(4)	(5)	(6)
(2)	22. I can best understand an individual by separately viewing, analyzing, his many different particular characteristics.	22.	(1)	(2)	(3)	(4)	(5)	(6)
*(3)	I can best understand an individual by viewing him as an entire person, and the manner in which all his characteristics interact.	23.	(1)	(2)	(3)	(4)	(5)	(6)
(4)	24. A well-functioning, healthy individual has achieved a fairly unchanging internal equilibrium.	24.	(1)	(2)	(3)	(4)	(5)	(6)
(4)	25. The members of a well-functioning, healthy family have achieved a fairly stable, unchanging set of relationships.	25.	(1)	(2)	(3)	(4)	(5)	(6)
(4)	26. The members of a well-functioning, healthy group have generally achieved a fairly unchanging set of relationships in equilibrium among one another.	26.	(1)	(2)	(3)	(4)	(5)	(6)
*(4)	27. A well-functioning, healthy individual is generally readjusting to his/her physical and social environment, and that environment is generally readjusting to him/her.	27.	(1)	(2)	(3)	(4)	(5)	(6)
*(4)	28. A well-functioning, healthy family is generally readjusting to its physical and social environment, and that environment is generally readjusting to it.	28.	(1)	(2)	(3)	(4)	(5)	(6)
*(4)	29. A well-functioning, healthy group is generally readjusting to its physical and social environment, and that environment is generally readjusting to it.	29.	(1)	(2)	(3)	(4)	(5)	(6)
(5)	It is ultimately possible to quantify the amount of influence of mind, body and environment on a person's behavior.	30.	(1)	(2)	(3)	(4)	(5)	(6)
(5)	31. The distinction between mind and body, psyche and soma, is extremely useful for understanding and conceptualizing human behavior.	31.	(1)	(2)	(3)	(4)	(5)	(6)
*(5)	32. The distinction between mind and body is not useful to understanding and conceptualizing human behavior.	32.	(1)	(2)	(3)	(4)	(5)	(6)
*(5)	33. The distinction between mind and body is not valid.	33.	(1)	(2)	(3)	(4)	(5)	(6)
*(6)	34. A well-functioning person's tendency to grow and develop is <u>naturally stronger</u> than his tendency to regress and disorganize.	34.	(1)	(2)	(3)	(4)	(5)	(6)

	(1) COMPLETELY AGREE	(2) AGREE	(3) NEUTRAL	(4) DISAGREE	(5) STRONGLY DISAGREE	(6) DOES NOT APPLY
* (6) 35. A well-functioning family's tendency to grow and develop is <u>naturally stronger</u> than its tendency to regress and disorganize.	35. (1)	(2)	(3)	(4)	(5)	(6)
* (6) 36. A well-functioning group's tendency to grow and develop is <u>naturally stronger</u> than its tendency to regress and disorganize.	36. (1)	(2)	(3)	(4)	(5)	(6)
* (6) People usually tend to seek an environment that will enable them to grow.	37. (1)	(2)	(3)	(4)	(5)	(6)
* (6) When I evaluate a case, I emphasize most current and potential strengths.	38. (1)	(2)	(3)	(4)	(5)	(6)
* (6) The most effective way to help a client is to work with his/her current and potential strengths.	39. (1)	(2)	(3)	(4)	(5)	(6)
(6) When I evaluate a case, I focus more on the blocks to utilizing strengths.	40. (1)	(2)	(3)	(4)	(5)	(6)
(6) When I evaluate a case, I focus more on areas of psychopathology.	41. (1)	(2)	(3)	(4)	(5)	(6)
* (6) When I evaluate a case, I emphasize more understanding ways of removing blocks to growth.	42. (1)	(2)	(3)	(4)	(5)	(6)
* (7) If we understand the nature of life, we can extrapolate to understand the nature of the individual.	43. (1)	(2)	(3)	(4)	(5)	(6)
* (7) If we understand the nature of life, we can extrapolate to understand the nature of human groups.	44. (1)	(2)	(3)	(4)	(5)	(6)
(7) If we understand specific physical scientific laws, we can extrapolate to understand the nature of the individual.	45. (1)	(2)	(3)	(4)	(5)	(6)
(7) If we understand specific physical scientific laws, we can extrapolate to understand the nature of human groups.	46. (1)	(2)	(3)	(4)	(5)	(6)
(8) 47. The most effective way to help a client is in an office like situation which is separate from the rest of his/her life and activities.	47. (1)	(2)	(3)	(4)	(5)	(6)
(8) 48. The most effective way to help a family is in an office-like situation which is separate from the rest of its life and activities.	48. (1)	(2)	(3)	(4)	(5)	(6)
(8) 49. The most effective way to help a group is in a situation apart from its regular activities.	49. (1)	(2)	(3)	(4)	(5)	(6)
* (8) I consider myself, as a helper, to be part of the environment in a case.	50. (1)	(2)	(3)	(4)	(5)	(6)

Note: Number to the immediate left of each item is the item number. These are the items in the 27-item final version.

Numbers in parentheses represent the original eight scales, of which only six scales survived (i.e., scales 1,3,4,5,6,8).

* Asterisk indicates reversal of score of an item to achieve correct value. Respondents' forms did not have asterisks, or scales.

APPENDIX C

Instrument-2

CLINICAL JUDGMENTS PROJECT
EZRA TEITELBAUM, C.S.W.

NEW YORK, N.Y. 10025

(212)

Dear Graduate Social Worker:

Thank you for your continued participation in the Clinical Judgments Project. Your First Questionnaire has been received. Enclosed is a check for \$5.00 for your effort.

You have been selected to complete and return a final Second Questionnaire, for which you will be paid \$10.00. I am requesting that you please make every effort to complete and return this item. The design of this phase of the research is such that just about every questionnaire which is sent out to selected respondents is needed for the final data collection, or my findings may not be valid.

Thank you for your cooperation and assistance. If you have requested, I will send you information about the study when my data have been sufficiently pulled together.

Once again, thanking you in advance for supplying what has been the heart of my research, so that I may earn my degree and make a contribution to social work knowledge, I remain,

Sincerely yours,

Ezra Teitelbaum, C.S.W., ACSW

Please indicate current information below, so that a check may be sent to you. This will be detached and filed separately from your responses.

Name _____

Address _____

Telephone: area code _____ number _____

TO THE READER:

YOU ARE BEING ASKED TO READ FOUR CASE VIGNETTES AND ANSWER QUESTIONS ABOUT EACH CASE IMMEDIATELY AFTER READING EACH VIGNETTE.

ASSUME THAT THE CLIENT(S) IN EACH CASE HAVE BEEN REFERRED TO YOUR AGENCY, AND THAT YOU HAVE TAKEN THE REFERRAL AND ACCEPTED IT ON BEHALF OF YOUR AGENCY. AFTER YOU HAVE READ EACH CASE, CONSIDER THAT YOU ARE THEN HALFWAY THROUGH THE FIRST FACE-TO-FACE CONTACT WITH THE CLIENT(S). THE INFORMATION IN EACH VIGNETTE REPRESENTS A SUMMARY OF WHAT YOU HAVE THUS FAR LEARNED ABOUT THE CASE FROM THE TIME OF REFERRAL THROUGH THE FIRST IN-PERSON CONTACT.

CONSIDER THE AGENCY YOU REPRESENT TO BE THE ONE IN WHICH YOU DID YOUR LAST GRADUATE STUDENT FIELD PLACEMENT. ASSUME THAT YOU TEND THEREFORE TO WORK WITH EACH CASE AS YOU WOULD IN YOUR AGENCY. ASSUME, HOWEVER, THAT AGENCY POLICY IS VERY FLEXIBLE SO THAT YOU ARE FREE TO HELP EACH CLIENT AS YOUR OWN BEST JUDGMENT INDICATES. YOU ARE NOT OBLIGATED TO FOLLOW CONSTRAINTS AND LIMITATIONS OF AGENCY POLICY.

(1-a)

David is age twenty. His parents, recently divorced professionals, had always been materially and affectionately generous to David. Their generosity became more pronounced five years ago after David's only brother completed college, married and moved out west. Parents' marriage had centered around providing for the children. The family had always lived in its own home in a small neighborly New England town.

David, due to be a senior in a college near home in the fall, says his parents expect him to go to graduate school, but that he has not even looked into this. Instead, he has been thinking about, and talking to friends, parents and college advisor about leaving home where he lives with father and finishing college somewhere else.

David has been edgy at home. He and father have been openly hostile to one another for the past year. He avoids much contact with mother who lives in the same town. He had been dating a young woman whom he had known since high school, but felt he was only seeing her more recently because she kept him away from home where he hated to be.

David came far to this City three weeks ago. He called his mother last week, long distance, collect, to say that he is fine and has money, but would not give his address. When David left home, he and his father were not on speaking terms.

David was referred to this agency by a friend who lives at the "Y" where David is staying. David expects to run out of money in about a month and says he does not know what he will do then. He dislikes the impersonal atmosphere at the "Y" but is having a good time meeting people in New York.

David's complaints include feeling that his parents bother him, that there is really nothing for him in his home town, and that he needs to think things out away from home, perhaps permanently.

David wants help in deciding what to do. He wants a "counselor" to help him think things out. He does not want a therapist to get into his head.

QUESTIONNAIRE

YOU HAVE JUST READ A CASE VIGNETTE. PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT IT:

1. BRIEFLY DESCRIBE YOUR ASSESSMENT OR EVALUATION OF THIS CASE. STATE YOUR REASONS.

2. BRIEFLY DESCRIBE YOUR INTERVENTION PLANS IN THIS CASE. STATE YOUR REASONS.

FOR EACH OF THE FOLLOWING STATEMENTS, THERE ARE TWO CHOICES, (a) OR (b) TO COMPLETE THE STATEMENT. FOR EACH STATEMENT, INDICATE YOUR PREFERENCE FOR COMPLETING THE STATEMENT BY RANKING CHOICES (a) AND (b) AS YOUR FIRST OR SECOND PREFERENCE FOR COMPLETING THE STATEMENT.

IN THE BLANK SPACE TO THE LEFT OF CHOICES (a) AND (b), PLACE EITHER NUMERAL "1" OR "2" TO INDICATE YOUR "FIRST" AND "SECOND" PREFERENCE FOR SENTENCE COMPLETION. REMEMBER, YOU ARE ASKED TO INDICATE A PREFERENCE, NOT AN ABSOLUTE CHOICE, SINCE BOTH CHOICES (a) AND (b) MAY BE VALID.

ON ASSESSMENT

3. The most effective way to define the problem or situation requiring help in this case is

_____ (a) to utilize all the information available to me from the client(s), referral sources and other sources, and then to formulate an assessment based on my professional expertise and knowledge.

_____ (b) to arrive at a mutual understanding with the client(s), through all the information available to us both.

4. In this case, the most effective way to define the problem as experienced by the client(s) is

_____ (a) to assess the limitations and deficits in the client's personality with reference to client capacity for change and growth.

_____ (b) to assess the client's currently available coping and adaptive capacities for change and growth.

5. In this case, the most effective way to define the problem as it exists in the environment is

_____ (a) to assess the limitations and deficits in the environment which prevent support of clients and which prevent meeting needs of clients.

_____ (b) to assess the available or potentially available resources to support clients and to meet needs of clients.

6. In this case, the most effective way to define the problem in its overall perspective is

_____ (a) to assess which internal aspects of the client's personality are accessible to change (e.g., ego growth, superego modification, conflict resolution).

_____ (b) to assess how well the needs of the client(s) mesh with the physical and emotional environment.

7. In this case, the most effective time frame for assessment is

_____ (a) to trace the history of the client(s) to understand the problem in the present.

_____ (b) to describe the interplay of current factors in the client's life to understand the present problem.

ON INTERVENTIONS

8. In this case, the most effective person(s) to decide on initial intervention plan is/are

_____ (a) the worker, as an objective expert.

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14. In this case, the most effective method of intervention is

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15. In this case, the most effective role (s) for the worker is/are

_____ (a) primary helper, or therapist.

_____ (b) enabler, advocate and/or broker, toward helping the client utilize his inner and outer resources to restructure his relationships with his environment.

16. In this case, the most effective explanation for lack of change despite intervention plans is

_____ (a) client resistance.

_____ (b) problems experienced between client and environment.

(1-b)

Martha, age nineteen, is living in the City with her parents and only sister age sixteen. Mother is a teacher and is home late afternoon every day. Father is a businessman, does very well financially, but keeps very long work hours. Martha is in her second year at city college. She entered college after completing art high school a year ago.

Martha's college advisor referred her to this agency after several talks with Martha. Martha also spoke with her mother about her distress.

Martha's complaints include anxiety and short-temperedness at home and with friends. Martha says her mother complains about her childishness, lack of cooperation at home, and late hours. Martha says her mother refuses to understand her and that she'll do as she pleases.

Martha has a good relationship with her college advisor. She participates in some school activities, and has a regular group of friends to whom she complains often about her mother, as well as about the men she dates. Martha speaks fondly about her father, but with lots of ambivalence in her open recognition that he is never home and never does anything with the family the way he used to.

Martha wants to feel less anxious about her school work which remains academically exceptional. She wants very much to feel less anxious about men and dating, and generally about making decisions for herself. She also wants her mother to get off her back. Her college advisor, who referred her for help, remains interested and available, as is her mother.

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FOR EACH OF THE FOLLOWING STATEMENTS, THERE ARE TWO CHOICES, (a) OR (b) TO COMPLETE THE STATEMENT. FOR EACH STATEMENT, INDICATE YOUR PREFERENCE FOR COMPLETING THE STATEMENT BY RANKING CHOICES (a) AND (b) AS YOUR FIRST OR SECOND PREFERENCE FOR COMPLETING THE STATEMENT.

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ON ASSESSMENT

3. The most effective way to define the problem or situation requiring help in this case is
 - _____ (a) to utilize all the information available to me from the client(s), referral sources and other sources, and then to formulate an assessment based on my professional expertise and knowledge.
 - _____ (b) to arrive at a mutual understanding with the client(s), through all the information available to us both.
4. In this case, the most effective way to define the problem as experienced by the client(s) is
 - _____ (a) to assess the limitations and deficits in the client's personality with reference to client capacity for change and growth.
 - _____ (b) to assess the client's currently available coping and adaptive capacities for change and growth.
5. In this case, the most effective way to define the problem as it exists in the environment is
 - _____ (a) to assess the limitations and deficits in the environment which prevent support of clients and which prevent meeting needs of clients.
 - _____ (b) to assess the available or potentially available resources to support clients and to meet needs of clients.

6. In this case, the most effective way to define the problem in its overall perspective is

- _____ (a) to assess which internal aspects of the client's personality are accessible to change (e.g., ego growth, superego modification, conflict resolution).
- _____ (b) to assess how well the needs of the client(s) mesh with the physical and emotional environment.

7. In this case, the most effective time frame for assessment is

- _____ (a) to trace the history of the client(s) to understand the problem in the present.
- _____ (b) to describe the interplay of current factors in the client's life to understand the present problem.

ON INTERVENTIONS

8. In this case, the most effective person(s) to decide on initial intervention plan is/are

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16. In this case, the most effective explanation for lack of change despite intervention plans is

_____ (a) client resistance.

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(2-a)

John Smith, age twenty-four, has one brother age twenty-seven. Parents died when John was in his late teens. He has had no contact with his brother for the past three years, although his brother has tried to help him.

John earned a college diploma in engineering three or four years ago. Work and living history are unclear since John was graduated from college and left his brother's home in Philadelphia to live in this City. Since then he has lived in transient fashion in both cities, where he spent a good part of his childhood. He has lived in transient hotels supported by public assistance for the past two or three years. He spends lots of time at the movies, in parks, and in his hotel rooms. He has no friend, and says he really does not need any.

John is seen regularly for brief appointments for medication renewal at the outpatient psychiatric clinic of a large local hospital. He says the medication keeps him calm.

John was referred to this agency through a social worker assigned to our new multi-faceted community outreach program which covers the hotel where John lives. They spoke for about half an hour this morning and John came to this agency this very afternoon asking to be seen.

John is not sure why he is coming to this agency for help, except that he was told that we might be able to help him with his situation. He does not seem to really understand what that means. He has some generalized intellectualized notions that "life can be more interesting," but he says he hasn't the vaguest idea as to how to go about it. He doesn't acknowledge anxiety when asked about his work history. He does, however, reveal that he lost his first professional engineering job after college for cursing at his supervisor. He says he has not been able to work since then.

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(2-b)

Mary Jones, age twenty-four, is two years younger than her only brother. Her brother is married, has a child, is successful in his own new business, and is living in the City. Mary has always lived with her parents who are now semi-retired in their mid-sixties. Brother and his family are frequent visitors, and are always helping out, doing favors for parents and sister. Mary's mother is controlling, dominating, pivotal in the household. Her father is emotionally distant and passive.

Since the age of seventeen, Mary has had several periods of psychiatric hospitalization. She has held several clerical jobs for brief periods, and has either quit "because of the pressure," or been fired. She has always lived home, except for brief periods in a halfway house after two of her hospitalizations.

Referral was made to this agency by the social worker at the halfway house which Mary recently left after a stay of a few weeks to return to live with her parents. The halfway house staff had, however, recommended that she not go home but continue to live there for at least a year.

Her complaints include serious anxiety about any new venture, times when she feels like she is floating, and episodes of hallucinations. When she is lucid, she has a sense that not only is she a real failure, but that even when she tries to succeed, at a job or at the halfway house, someone underhandedly causes her to fail.

Although she has taken various sorts of psychotropic medication for the past several years, Mary has never had shock therapy. She also has never seen the same therapist for more than a year.

Mary wants to feel better. She does not want to have to go in and out of hospitals all her life. She says, when asked, that she wants her brother to offer to take care of her when her parents die or become too old, which is one of her greatest and most haunting fears.

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